Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 1805 OUISE /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Death Examiner Allegar errace and If Under 24 Hrs. 6. Sex NS 9. Sirthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** 5. Social Security Number Months Days Hours 1□ M 2XF 80 Director 220 16 253 MD Usuel Residence of Decedent Peges 1 and 2 should be filed within 72 hours efter deeth with the Maryland 10b County 10c. City, Town or Location 10a Stete 10d. Inside City Limits 1 Yes 2 □ No Director umber 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code 21502 Completed by Funeral errace 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Maritaf Status Black, White, etc. 1 ☐ Never Married 2 Merried Baltimore, Maryland 21215-0020 ò 1□ Yes 2X No Specify: Specity: White of Heelth end Mental Hygiene. Item 27 is marked other than "naturel", of other treumatic event, the Medical Exer 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) romema 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kichar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 21502 20b. Place of Disposition (Name of cemetery, cremetory or other plece) WVU 20a. Method of Disposition 20c. Location - City or Town, State Date Depertment of Important: If It eny Injury or o 70 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 1418 22. Name and Address of Facility Himan Gift Recistry WVII 4052 Health Sciences North Morgantown, www 26506 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, of complications that resed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause the each line. Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical CAncer Examiner e to (or es a consequenç Medical Certification: To Be Completed by Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed the buriel-trensit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): within 24 hours efter death. To the Funeral Director: After this certificate has been signed by the e completely filled in by the funeral director, page 2 should be deteched? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 4 Wiknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 21016 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28c. Injury et Work? 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 2 No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 1 e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier

State Registrar **DHMH 16 Rev 6/95**

29b. Signature and title of certifier

30. Neme end address of pe

ated cause of death (Item 23e) (Type, Print)

32. Registrer Signature

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Alice Crawford 2004 Bernice Im /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Cambridge

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) (Month, Day, Yeer) Dorchester Mallard Bay Nursing Home 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** Months 1□M 2XF Yrs. Director 161-16-8283 91 March 14,1912 Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show of Health and Mental Hygiene.
Item 27 is marked other than "natural", or Items 23a or 28e-1 show other traumatic event, the Mudical Examiner must be notified at 1 ☐ Yes 2 ☐ 100 Director Maryland Dorchester <u>Hurlock</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with (P.O.BOX 395) 21643 6662 Cabin Creek Road USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: 3 X Widowed 4 □ Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) House Keeping 10 Cold Water 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental 0 Carvilla Mae Johns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22913 Dover Bridge Road, Preston, Maryland 21655 Eleanor Williams / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Murial 2 □ Cremation 3 □ Removal from State = 5 permit. Page Department (Importent: If any injury or * 4 ☐ Donation 5 ☐ Other (Specify) Washington Cemetery 01/09/2004 Hurlock, Maryland 21. Signatura of Funeral Se Pannie Smith Funeral Home 516 S. Main Street, Hurlock, Maryland 21643 rince Tun 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** e Ate ? 3 mos /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician ian/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal deal
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Physic P.O. 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 23 No 1 Tes 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 🔀 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 25€No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 3 DOA 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after death To the Funerel Director: 6 Could not be determined 3 ☐ Suicide I in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dev. Year) 638 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MA adden 302 CollING 31. Date filed (Month, 32. Registrar's Signature State Registrar

1 - For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legibls.

State of Maryland / Department of Health and Mental Hyg	giene	20	101	0	9	£ 1	Λ.	0
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Physic /Medi Exami

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If itam 27 is marked other than "natural", or Itams 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospitel or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit within 24 hours after death.

To tha Funeral Diractor: After this certific completely filled in by the funeral director.

Division of Vital Records, P.O. Box 68760,

TONIAC CHARLERON 4. Folia Name (in detailing) gets street and number) 4. City Town of Location of Osean Route 318 and Route 331 5. Sould Secure Yourse 219-57-9713 4. Route 318 and Route 331 7. Age (in yez also Secure) 129-57-9713 4. The property of the Secure of Secu		1. Decedent's Name (F								2. Date of D		ay Year	3. Time of	Death
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Committee Comm	20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - Ci												MD 21	632
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Securative Sec		shock, or heart fa	ilure. List only	one cause on each li	ne.		,	•						
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		1tan	1 1	mi -t	St Val	ناب	O.C.M	.E.			Jan	uary 9, 2	2004	

State

111 Penn Street, Baltimore, Maryland 21201

39 Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHICA

32. Registrar's Signature

1000

31. Date filed (Month, Day, Year)

3

2004

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				For State Registrar	State of M	-	Department of Certificate of			g. No.	04 (01504
		Discosio:		1. Decedent's Name (First, Middle, L	ast)				2. Date of Deat Month	h Day	Year	3. Time of Death
		Physici /Medio		WILLIAM	DAVID	CROPPE	ER SR.				004	0210 M
		Examir		4a. Facility Name (If not institution, g				, or Location of Death		4c. County		
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		Funeral Director		217-30-9709	Sex 7. Ag	e (In yrs. last bir 67	Yrs. If Under 1 Yea Months Day		8. Date of Birth (Month, Day, June 5,	1936	9. Birthplece Country) Maryl	e (State or Foreign Land
		yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location				10d.	Inside City Limits
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	9	be filed within 72 hours after death with the Maryland tal Hygiene d other than "natural", or itema 23a or 28a-f ahow avant, the Madical Examinat must be malified at	Funeral Director	11. Marital Status 1 ☐ Never Married 2 【※ Married	12. Was Decedent Armed Forces? 1 XYes 2	No		f Hispanic Origin? (Spuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	Bleck	- American I c, White, etc.	
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a	7	be filed withintal Hygiene. Id other then	ပိ	17. Father's Name (First, Middle, Lat	=======================================		Sales Manag		e (First, Middle, M	Chevrol		Les
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dist	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other treumatic upes.		Joanne Cropper/			7320 Levin	Dashiell	Rd., Heb	oron, MI	21830	0
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11.	Balti	permit. I Departm Importar any inju		21 Signature of Funeral Service Lic			22 Name and Add HOILOWay	ress of Facility Funeral I	Home Prof	essiona	al Asso	ociation
		40264			molerations that cause	CFSP	DOT SHOW	HIII Rd.	, Salisbu	icy, MD	21804	proximate
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	Se .	e law has b je 2 si	Completed						24a. Was an autopsy perform	ed2 pr	or to comple eath?	findings available etion of cause of
	<u>a</u>	uician: Th certificate rector, pag	e Cc	25. Was case referred to medical	4						☐Yes 2☐	i No
	<u>=</u>	Physician: rthis certific ral director,	o B	examiner?	Hospital:	ent 2 ER/Ou	tpatient 3 DOA	ther	h (Check only one		- (Canaita)	
	o to	nding Physician: th. : After this certifica funeral director, p	I=	27. Manner of Death	28a. Date of Inju	ry 28b. 1	Time of 28c. Inj		ome 5 🗌 Resider 28d. Describe how			
	sion	el or Attending F s after death. I Director: After d in by the funera	cation	Natural 5 ☐ Pending 2 ☐ Accident investigate 3 ☐ Suicide 6 ☐ Could not	he		M 1[∏Yes 2 ☐No				
	Divi	ital or At rs after or al Directed in by	Certification:	4 Homicide determine	d 289. Place of Inj	ury - At home, 1a c. (Specify)	rm, street, factory, office	9	28f. Location (Stre City or Town,		r or Rural Ro	ute Number,
		To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier Check only one) Certifying F	Physician: To the best aminer: On the basis o and manner st	f examination and	e, death occurred at the d/or investigation, in my	time, date and place, opinion, death occur	and due to the car red at the time, da	use(s) and man te and place, ar	ner as stated nd due to the	l. cause(s)
	•	To the within To the comp	Me	29b. Signature and title of certifier	w.M		29c. Lice	No se number	29	d. Date/signed	(Month, Day,	Year)
01	1.4	~		30. Name and address of person wh	completed cause of c			011		.1010	100 /	- /
9+1	VA	XX.		Kurt Henberg	/		CE ALUFF R	0 SA	Usburg	mo	2/80	2/
1		Sta Registr	_	JAN 0 6 21	32. Registr	ar's Signature	9 Spork	2				

		For State Registrar	State	of Marylai		artment of H			ene g. No. 20	04	01505
		1. Decedent's Name (First, Middle	e, Last)					2. Date of Death Month	Day	Year	3. Time of Death
Physici /Medi		Sarah Ger						January			6:30 P M
Examir	ner	4a. Fecility Name (If not institution Millennium Hea	-			_	Location of Death		4c. County		lo1
		5. Social Security Number	6. Sex		. last birthday)	Edgewa	If Under 24 Hrs.	8. Date of Birth (Month, Dey,	Anne		ace (State or Foreign try)
Funeral Director		224–48–2915	1□M 2/2 F	91	Yrs.	Months Days	Hours Min.	July 15	,1912		sylvania
		Usual Residence of Decedent									Od. Inside City Limits
arylar show	_	Maryland Anne	Arundel	10c. C	City, Town or Lo		Mayo				1 Yes 2 XNo
ith the Marylar or 28a-f show	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of W	hat Coun	
with t	ā	1220 Pine Avenu	e				1106		USA		.,
ms 23	Funeral	11. Marital Status	12. Was Dec	edent Ever in	U.S. 13.	Was Decedent of H If Yes, specify Cuba		ecify Yes or No-	14. Race	- America	
after or Its		1 Never Married 2 Mar	If Yes. G	2 XNO		1 ⊡Yes 2 XX No	Specify:	riican, etc.)	Specify:		
72 hours after death w "natural", or Items 23a	d by	3 XWidowed 4 ☐ Divorced	Year or	Dates:			-4:	1.	6b. Kind of Bu	Wh	ite
n 72 i	Completed	(Specify only highe			(Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work i)	ring	ob. Kind of bu	SILIGOSVILIC	lustry
y withi	mo	Elementary/Secondary (0-12) 12th	College	(1-4or 5+)	Sa	alesperso	n		Departn	nent	Store
a filec at Hyg other	BeC	17. Father's Name (First, Middle,	Last)	<u> </u>			18. Mother's Nam	e (First, Middle, M	aiden Sumam	9)	
is 5, intally fall of ELECTOOOO s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-f show other treumatic event, the Madical Examinating the myllind at	To E		. Keener					isa Ulri			
2 sho		19a. Informant's Name/Relations				ng Address (Street a					Code)
C, In 1 and 1 and 4 ealth ealth ther t		James W. Chane 20a. Method of Disposition	y/ SOII	20b.	The second second second	2 Beach Rouse of matory or other place			Oc. Location -		wn, State
ot of the state of or of the state of or of the state of		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		1 State		matory or other place Mem'l. Pa	i	. 04	Falls (huma	h 177
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any njury or other freumatic event, the Mance.		21. Signatur Fy eral Service		140		2. Name and Addres					
Depa Impo Impo sny ir	100	> Mount a	fel			973 Solom					
to Allia	Г	23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that only one cause on	caused the dea	ath. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arre	st,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	, (ances	DF	the Hec	ici & N	eck with	n metas	1451	Onset and Death
/Medical Examiner	l	resulting in death)	Due to	(or as a conse							
	70	Sequentially list conditions, if any leading to immediate	Due to	(or as a conse	equence of):					-	
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	'								
exection and and rial-tra	Exa	resulting in death) Last	C. Due to	(or as a conse	equence of):						
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ical		d								
vequires that the death certificate signed by the attending of should be detached for use as t	Physician/Med	IF FEMALE:	220 16 400 0	uteems of eros	2222		7	10000		1	
attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome of pregi birth 2 ☐ Fe gnant at time of	tal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date Mor	e of delive nth	ry Day Year
the d	iysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unk		Joann St						
s that	by Pr	Part II. Other significant conditi	ons contributing to	death but not re	esulting in the u	inderlying cause giv	en in Part I.	23e. Did tob	acco use contr	ibute to th	e cause of death?
w requires to been signer should be								1 🗌 Ye	s 2 🗆 No	3 Prob	ably 4 Tunknown
law re as bec	Completed							24a. Was an autopsy	24b. V	Vere autor	osy findings available inpletion of cause of
ding Physician: The lav h. h. After this certificate has funeral director, page 2	Com							perform 1 ☐ Yes 2	ied?/ d	eath?	
VICAL ician: Tertifica sertifica ector. p	Be	25. Was case referred to medica examiner?	Hospital:			Oth		th (Check only one			
Phys. this and dir	10	1 Yes 2 No	28a. Dat		ER/Outpatie		er: 4 XNursing Ho	ome 5 Resider 28d. Describe hor			")
ding th.: After	tion	1 Natural 5 Pendi	/4.4.	nth, Day Yeer)	Injury		k? Yes 2 □ No				
Attending ar death. ector: Atteby the fune	Certification:	3 Suicide 6 Could 4 Homicide deterr	nined 200. Plat	e of Injury - At ding, etc. (Spec		reet, factory, office		28f. Location (Str. City or Town,	eet and Numbe State)	er or Rura	l Route Number,
rs after or salter or salt	Cert	- I TIONIIO GO			,						
To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical	ng Physicien: To the Exeminer: On the	basis of examin	nowledge, dea: nation and/or ir	th occurred at the tin evestigation, in my o	ne, date and place, pinion, death occui	and due to the ca red at the time, da	use(s) and ma te and place, a	nner as st and due to	ated. the cause(s)
o the ithin 2 o the omplei	Med	one) 29b. Signature and title of certific		nner stated.		29c. Licens	e number	29	d. Date signed	(Month,	Day, Year)
F 3 F 8		1 Cryc		Suran	rVi	D	50653		1-1:	2 - 3	2004
		30. Name and address of person	who completed ca	use of death (It	em 23a) (Type			SURAN		A=7/-	-1
		5851 - 32 31. Date filed (Month, Day, Year		Registrar's Sig		Road.	Decile	\sim m	D. 2	075	
St Regist	ate trar		2 2004	Con	K	book					

3		1	For State Registrar	State of	Maryla	nd / Depa	artmen rtificat			and Mo		giene Reg. No.	200) [;	01506
	sicia edica		Decedent's Name (First, Middle, Roland Colbe	rt							2. Date of De Month Januar	Day	2004	er 2	Time of Death
Exa	mine		ia. Facility Name (If not institution, 536 N. Pulaski 5. Social Security Number	Street	7. Age (In yrs	. last birthday)	Ba If Under	ltimo	If Under a	24 Hrs.	8. Date of Birl	th	Balti	more	City (State or Foreign
Direc		L.	218-26-7668 Usuel Residence of Decedent	1MM 2□F		70 yrs.	Months	Days	Hours	Min.	une 2	5 19	933	D.C.	
DEILIMOTE, INICITIES AND PARTIES AND POUS ABOUT PARTIES PROMISE PROPERTY PARTIES AND PARTI	regical Examiner court of natives at	rai Director	10a. State 10b. County 10aryland 10b. County None 10c. Street and Number 536 N. Pulask 11. Marital Status 12. Never Married 2 Marrie 3 Widowed 4 Divorced 15. Decedent's (Specify only highest	12. Was Dece Armed For 1	dent Ever in loces? 2 SNo e lass:	16a. Dece	10f. Zip 21 Was Decedif Yes, spe- 1 Yes	223 dent of Hi cify Cuba 211 No	Specify:		cify Yes or No Rican, etc.)	U\$	14. Race - A Black, N Specify:	American In White, etc. Blace	ndian,
yiarra 616 buld be filed within Mental Hygiene. arked other than	atic event, me a	To Be Com	Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, L Roland Colber		-40r 5+)		PN-N		18. Mothe	ra H	(First, Middle,	, Maiden d			
ges 1 and 2 sho lof Health and Hitem 27 is my	or other traum	-	19a. Informant's Name/Relationshingerry T. Brown 20a. Method of Disposition 1 □ Burial ※XX remation	(Nephew	20b.	2326 Place of Dispo cemetery, crea	Euta esition (Name	NW P	lace	Ba1	timor	e , 1	1d. 2	21217 y or Town,	State
Dallimor	once.	-	* 4 □Donation 5 □ Other (Sp. 21. Signature of Funeral Service L			tro Cr Wn	Name ar R∈	nd Addres	s of Facility	-9-0 ons	Mortu	ary	imor , P.A	۱.	ld.
Certificate be executed Certificate be executed Examil Additional physician and	ner nigural-transit	lical Examiner	23a. Part1. Enter the disease, or of shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Arte Due to (c) b. Due to (c) c	ach line.	erotic quence of):	er the mod	e of dying	g, such as	cardiac or	respiratory ai			App	proximate aval Between set and Death
death certific	or use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		irth 2 ☐ Fei ant at time of	al death 3	□Ectopic pi □ Other (sp					12	23d. Date of Month	f delivery Day	Year
ne law requires that the de has been signed by the a	ed bluous 2	ompleted by Ph	Part II. Other significant condition	s contributing to de	ath but not re	sulting in the u	nderlying o	ause give	en in Part I.			Yes 2[an	□ No 3 [Probably	ause of death? 4 DUnknown findings available tion of cause of
The The	ο.	O	25. Was case referred to medical						26. Place	of Death	nerfo	2 No	deat	h?	
Phys this	al dire	ertification: To B	examiner? 1 X xes 2 No 27. Manper of Death 1 Natural 5 Pending 2 Accident investig: 3 Suicide 6 Could no	28a. Date of (Month	of Injury h, Day Year)	28b. Time o	f A	28c. Injury Work	4 🗆 Nu	No 2	ne 5 ☐ Reside 8d. Describe 1	how injur	y occurred		At scene
pital or Al	filled in by	ပ ၂	4 ☐ Homicide determin	and 286. Place	ng, etc. (Spec				ne date ac		8f. Location (S City or Tov	wn, State)		
UNISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After	completely filled in	Medical		xaminer: On the ba	sis of examin		vestigation		oinion, deat		d at the time,	date and		due to the	cause(s)
		-	30. Name and address of person w	Ime Um	e of death (Ite	em 23a) (Type,		O.C.1	1.E.			Janu	ary 5	, 200	4
Re	Stat gistra	G	Margarita Kore 31. Date filed (Month, Day, Year)	32. R	edistrar's Sign	nature	111	Penr	Str	eet,	Baltim	ore,	Mary	land	21201

			For	State of M	arylan					ental Hy	giene	01507
			1 - State Registrar			Cei	rtificate	of Deat			Reg. No. CUUI	1 UCIOU/
	Physicia	an	Decedent's Name (First, Middle, La	-						Date of Dea Month	Day Year	* * * * * * * * * * * * * * * * * * * *
	/Medic	ai	Walter Stanton C				4h City Tou	vn, or Location		January	7 5, 2004 4c. County of Dec	1,000
	Examin	er	Genesis Eldercar					erna Pa				
	Funeral		5. Social Security Number 6. S			ast birthday)	_if Under 1 Y	ear If Und		8. Date of Birt (Month, Day		rundel rthplace (State or Foreign
	Director		276–12–0049	XM 2□F	84	Yrs.	Months D	ays Hours	Min.	Mar. 3		assachusetts
P	>		Usual Residence of Decedent		100 Cin	, Town or Lo	eation					
Z Z	shov	7	MD 10b. County Anne Ar	undel	1	asaden						10d. Inside City Limits 1 ☐ Yes 2 XNo
the N	28a-f	ect	10e. Street and Number				10f. Zip Co	de			10g. Citizen of What C	
¥ th	l be	0	8100 Elmberry Cou	rt Apt.	# 130	12		21122			USA	,
death	ms 2:	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.				Origin? (Spec	cify Yes or No- lican, etc.)		
affer o	ar te	Fu	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 [XYes 2 [] If Yes, Give	No WW	TT	ires,specπy 1∐ Yes 2∭∑			(ican, etc.)		
Surs	F G	d by	3 Widowed 4 Divorced	Year or Dates:	Korea	an	10163 2,40	140 3,060			Specify: [W]	
2 2	nati	Completed	15. Decedent's E- (Specify only highest gra			(Give	dent's Usual O kind of work d DO NOT use r	one during m	ost of workin	g	16b. Kind of Busines:	s/Industry
¥ 1	ene. than	щć	Elementary/Secondary (0-12)	College (1-4or	5+)	me.	Manage				Shoe St	ore
III.Q Z I Z I 3-0050 be filed within 72 hours after death with the Maryland	Hygi other ent, I	a	17. Father's Name (First, Middle, Last,)					ther's Name	(First, Middle,	Maiden Surname)	010
<u>a</u>	ked ked ic ev	To B	Walter S. Cook,	Sr.					Kathry	me H.	Hardenburg	h
al yla	and N s mai		19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (St				r, City or Town, State,	
and 2	n 27 I		Linda Ferguson/Da	aughter		8100) Elmbe	rry Co	urt Ar	ot. 130		a, MD 21122
- C	i ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	C	emetery, crer	sition (Name on matory or other	place)	Janua	ary 9,	20c. Location - City o	r Town, State
	tment tent: jury		'4 □ Donation 5 □ Other (Special	7			ans Cem		200)4	Crownsvil	le, MD
	Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It's Medical Examinar must be notified at once.		21. Signature of Fune al Service Lice	îsee		B	Name and A Prranco 95 Gov.	ddress of Fac & Sop	is, P.7	. Sev	erna Park	Funeral Home MD 21146
			23a. Pay 1. Enter the disease, or com	plications that caused	the death							MD 21146 Approximate
n	hinina		shock, or heart failure. List only Immediate Cause (Final	one cause on each li	ine.				1	,	1. 1	Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	Due to (or as	a consequ	uence of k	eal '	nusci	ular	dys	rophy	years
Ε	xaminer		Conventially list and distant	h							0	
70	=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as	a consequ	ence of):						
ecute	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	2 22222	iones of):						
S S S S S S S S S S S S S S S S S S S	hysician and the burial-transit	cai E		Due to (or as	a consequ	2611C6 O1).						
Cate	phys s the			_ d								
Certii	nding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			-				23d. Date of de	alivery
death	e atte	Physician/Med	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pregn Other (specif				Month	Day Year
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, a	been signed by the attending pt should be detached for use as t		Part II. Other significant conditions	/	out not resu	2		1-	t I.		bacco use contribute	
	een s binor	ted	Chronic Obstr	ucrue_	pul	1000	rary	VISE CO	se_	1 4	'es 2 □ No 3 □ P	robably 4 Onknown
§ §	has b e 2 sl	Completed by					0	-		24a. Was a autop perfor	sy prior to	utopsy findings available completion of cause of
ב ב	icate r, pag									1 Yes	2 ☐ No 1 ☐ Ye	s 2 No
VIII.	certif	Be c	25. Was case referred to medical examiner? 1 \(\sum \text{Yes} 2 \sum \text{Yo} \)	Hospital:		ER/Outpatien		Othor		(Check only of		
5 \$	h. After this certificate has funeral director, page 2 s	n: To	27. Manner of Death	28a. Date of Inju	ıry	28b. Time of		Injury at Work?			lence 6 Other (Specow injury occurred	эспу)
	ath. e fun	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Da	y Year)	Injury		work? 1 ☐ Yes 2 [□No			
V Atta	racto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined				eet, factory, of	fice	2	8f. Location (S City or Tow	Street and Number or F	lural Route Number,
5 📲	rs aft rel Di	Cer										
DIVISION OF VITAL MECOLOS, F.O. BOX 80/80,	within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical		niner: On the basis o	f examinat						cause(s) and manner a date and place, and du	
othe	ithin a the o the omple	Mec	29b. Signature and title of certifier	and manner st	ateu.		29c. Li	cense numbe	r	2	29d. Date signed (Mon	th, Day, Year)
Ä	ĕ⊢ŏ			112	- 1	MD	7)50	725	S	1-5-	2004
			30. Name and address of person who	completed cause of c	death (Item	23а) (Туре,	Pṛint)	11		//		
			Jemiter Rie	dinger	-860	1 Vel	teran	Hw	y M.	llersv	1-5-	1) 21108
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 8 20		ar's Signat	ture	antle	0	, —			
	1166 1201	GII	V V L			100						

_			1 - For State Registrar	State of Ma	aryland / [tment of I		ind M		ene 2 (004		508
	Physici	an	1. Decedent's Name (First, Middle, Las							2. Date of Death Month	Day	Year	3. Time of	Death
	/Medi		Mary Francis (January	8 2	004	2:50	A^{M}
	Examir	ner	4a. Facility Name (If not institution, give		,	41	b. City, Town,				4c. County	of Death		
		-	Anne Arundel Me 5. Social Security Number 6. Se		ter e (In yrs. last bir	thday) li	Au f Under 1 Year	nnapol.	is A Hrs	9. Date of Birth	Anne	Aru		
	Funeral Director			_M 2⊠F			Months Days	Hours	Min.	8. Date of Birth (Month, Day, May 30,	1926	Cour	ilece (State o itry) /land	r Foreign
	yland how		10a. State 10b. County		10c. City, Town	n or Locati	ion					1	0d. Inside Cit	ty Limits
	e Mai	ctor	Maryland Anne Ar	rundel				Annaj	polis	3			1 Tes	200No
	ith th	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of V	Vhat Cour	itry?	
	ath w	rai	24 Oak Court						401			.S.A.		
	er de Items	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		13. Was	s Decedent of F es, specify Cub	Hispanic Orig an, Mexican,	in? (Spec Puerto R	cify Yes or No- lican, etc.)		e - Americ k, White,		
36	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2☐ If Yes, Give Year or Dates:	NO	10	Yes 2 XNo	Specify:			Specify	: Whi	.te	
Š	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or tlems 23a or 28e-f ahow int, the Modfed Examiner must be notified at	ted	15. Decedent's Ede	ucation	16a.	Decedent	t's Usual Occup	pation		10	Sb. Kind of Bu	siness/Inc	dustry	
212	thin 7	ple	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4or 5	+)	(Give kınd lite. DO	d of work done NOT use retire	during most : d)	of workin	g			,	
7	ed wil	Completed	7			H	omemake	er			Own	Home	<u> </u>	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23a or 28e-f ahow with injury or other traumatic avant, the Moulcal Extending must be notified an ance.	To Be	17. Father's Name (First, Middle, Last) Edward Craig							(First, Middle, Mi Fitzhugh	aiden Sumam	ne)		
Man	and 2 sho ealth and i n 27 is mu		19a. Informant's Name/Relationship (T) Susan Morris/dau				Address (Street k Court			Route Number, (City or Town,	State, Zip	Code)	
Baltimore,	of He of He litem		20a. Method of Disposition		20b. Place of cemeter	Disposition	on (Name of ory or other pla	ce)	Da	ite 20	c. Location -	City or To	wn, State	
Ĕ	Pages nent of I ant: if its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)				em. Gar		1/10	/2004	Annapo:	lis,	MD	
ä	permit. Page Department Importent: if any injury or once.		21. Signature by Funeral Service Licens	9	1//	22. Na	ame and Addre	ss of Facility	Johr	M. Tay	lor Fu	neral	Home	
	40.5 4 9	()!	23a. Part1. Enter the disease, or comp	1 2	llen	14/	Duke c	ot Glou	ıcest	er St. A	Annapo.	lis,	MD 214	101
be executed Wedical Wedical Wedical Price and			shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Securitially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or a) Due	stive He a consequence of censive a consequence of	of): Cris: of):							Interval Betw Onset and D days days	
P.O. Box 687	The law requires that the death certificate te has been signed by the attending phys age 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 255No 9 □ Unknown	d	2 Fetal death		opic pregnancy her (specify) _	,		1112	23d. Date Mon	e of deliver		ear
	uires tha	by	Part II. Other significant conditions con Alzheime:	ntributing to death bur's Diseas		the under	rlying cause giv	en in Part I.		23e. Did tobad	cco use contri			
00	w require been sign should b	lete								24a. Was an			sy findings a	
Vital Records,	(D) 14	e Completed	25. Was case referred to medical							autopsy performe 1 Yes 2 ∑	d? di	rior to comeath?	pletion of ca	use of
		o Be	examiner?	lospital: 1 🔯 Inpatier	nt 2□ER/Out		Oth			Check only one)				-
0	g Physer this eral di	\vdash	27. Manner of Death	28a. Date of Injury (Month, Day		ime of	28c. Injun	4 Nurs		d. Describe how			1	
0	Attending Is death.	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) In	ijury I		k? Yes 2∐No						
DIVISION	el or Atte s after de il Directo d in by th	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At home, far . (Specify)	m, street,	factory, office		28	f. Location (Stree City or Town, S		r or Rural	Route Numb	er,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fi	edical C	29a. Certifier 1 ☐ Certifying Physical Check only 2 ☐ Medicel Examination	sician: To the best of ner: On the basis of and manner stat	examination and	death occ	curred at the tin igation, in my o	ne, date and pinion, death	place, an	d due to the caus at the time, date	e(s) and man and place, a	iner as sta	ted. the cause(s)	
	To the To the Comp	Me	29b. Signature and title of certifier	1	1		29c. License			29d.	Date signed	(Month, D	ay, Year)	
			12N V	~//	SIN		D	005695	5		Jan. 8	, 200)4	
			30. Name and address of person who co											
			Bryan J. McVerry	AAMC 20	02 Medi	cal F	Parkway	Annaı	polis	s, Maryl	and 2	1401		
Ť	Sta Registra	-	31. Date filed (Month, Day, Year) JAN 0 9 20	32 Medistra	r's Signature	Some	11			-				

			For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of He		lental Hy	giene 0	04	01509
			Decedent's Name (First, Middle,	Last)	****	<u></u>		2. Date of De			3. Time of Death
	Physicia		Mary Ann	a Cı	ross			Jan 1	2004	Year	1:15 A ^M
	/Medic Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or L	ocation of Death		4c. Count	of Death	1 1 1 3 11
	LXdillill	C.	Moran Manor	Nursing Ho	ome	Wester	nport		Δ11	egan	W
	Funeral			Sev 7 Ans	e (In yrs. last birthday)	If Under 1 Year		8. Date of Bi (Month, D	irth	9. Birthp	lace (State or Foreign
	Director		202-26-5720	1 M 2 LF	97 Yrs.	Months Days	nours Min.		8 1906	Mar	yland
	pu ,		Usual Residence of Decedent		40. Ci. T						
	shov	_	10a. State 10b. County		10c. City, Town or Lo					1	Od. Inside City Limits
	8e-f	ctc		egany	Wester	T					1 Yes 2 □ No
	or 2	Director	10e. Street and Number	_		10f. Zip Code			10g. Citizen of	What Cour	itry?
	be filed within 72 hours after death with the Maryland hat Hygiene. ad other than "natural", or Items 23e or 28e-1 show event, the Medical Examinar must be notified at	Ta	233 Maryland				562		Unite		
	er de	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Sp. , <mark>Mexican, Pu<i>e</i>rt</mark> o	ecify Yes or No Rican, etc.)	o- 14. Ra	ce - Am <i>e</i> ric .ck, White,	
36	s aft	by F	1 Never Married 2 Marrie 3 Widowed 4 Divorced	d 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	10	1 ☐ Yes 2 ☐XNo	Specify:		Specia	y: Wh	ite
응	tural tural		15. Decedent's		16a Daca	dent's Usual Occupati	ion		16b, Kind of B		
5	in 72 " na Pedic	Completed	(Specify only highest	grade completed)	(Give	kind of work done du DO NOT use retired)		ing	160. Kind of E	usiness/inc	dustry
5	with ene. ther	E	Elementary/Secondary (0-12) Unknown	College (1-4or 5	+)	id			Homec	are	
р.	filed Hygie other		17. Father's Name (First, Middle, L.	ast)			8. Mother's Nami	e (First, Middle			
an	d be ental ked c	To Be	John Cross				Anna V	idiki			
7	es 1 and 2 should be of Health and Mental fitem 27 is marked r other treumetic ev	-	19a. Informant's Name/Relationshi	p (Type, Print)	19b. Maili	ng Address (Street an			per, City or Town	State, Zip	Code)
ž	nd 2 slutth an 27 is r		Julia Price			Marylan					
5	s 1 and 2 f Health item 27 i	1	20a. Method of Disposition		20b. Place of Dispo			Date	20c. Location		
5	age: ent o nt: If y or		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		St Pete		1	3 200	4 West	0 20 20 20	ont Md
Baltimore, Maryland 21215-0036	permit. Pages 1 Deportment of H Importent: If ite any injury or ot once		21. Signature of Funeral Service Li) 2	Name and Address	of Facility				ort, Ma
ã	Dep Imp		12 Way	re (And	E W	oal Fune esternpo	ral Hon	ne,111	Churc	h St	
			23a. Part1. Enter the disease, or c	omplications that caused	the death. Do not en				arrest,		Approximate
	Photototot		shock, or heart failure. List o Immediate Cause (Final			. 1 - 1	1 1	(5)			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to for as	a consequence of);	ockrain	Info	rotion	1	-	Shours
	Examiner			Due to (or as	a consequence of):	Aulan	0.70				112.28
		<u>a</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence or,	pryery	N Sec	ar		-	gene
	uted	튙	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
÷	exec n and ial-tra	Examiner	resulting in death) Last	Due to (or as	a consequence of):						
8760,	the death certificate be executed y the attending physician and sched for use as the burial-transit	dlcal		d							
9	tifical g phy as th	ed		_							
Вох	eath certific attending p	5	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnancy			23d. Da	ite of delive	ery
Ω.	deatl	lcla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at		Other (specify)			Mo	onth	Day Year
P.O.	that the de ed by the a detached f	Physician/Me	9 Unknown	9□ Unknown							
S, F	res tha igned be de	by F	Part II. Other significant condition	4			in Part I.	23e. Did	tobacco use con	tribute to th	ne cause of death?
ğ	w require been si should b		Organic	Brain	Syndro	me		1 🗆	Yes 2□No	3 🗌 Prob	ably 4 Thinknown
Division of Vital Records,	The law requires that ste has been signed b age 2 should be deta	Completed)					24a. Was		Were auto	psy findings available
æ	The ate ha	E						auto perfe 1 Yes	ormed?	death?	mpletion of cause of
ita		Bec	25. Was case referred to medical			2	26. Place of Deatl		7.		
1	g .s. 5	Jo E	examiner? 1 ☐ Yes 254No	Hospital: 1 Inpatie	nt 2 ER/Outpatie	nt 3 DOA Other:	4 Nursing Ho	me 5 ☐ R <i>e</i> s	idence 6 □Ott	ner (Specify	()
0	ng Ph ter th neral		27. Manner of Death 1 Setural 5 □ Pending	28a. Date of Injur (Month, Day	y Year) 28b. Time o	f 28c. Injury a Work?			how injury occur		
Ö	Attending F r death. sctor: After by the funera	atic	2 Accident investiga	ition			es 2□No				
Ξ̈́	or Att	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (City or To	(Street and Numb wn, State)	er or Rura	I Route Number,
Ω	itel o	Se									
	To the Hospitel or Attent within 24 hours after death To the Funerel Director; completely filled in by the	edical	(Check only 2 Medical E	Physicien: To the best oxeminer: On the basis of	examination and/or in	h occurred at the time.	, date and place, nion, death occurr	and due to the	cause(s) and m	anner as st	ated.
	To the I within 2. To the I complet		one)	and manner sta	ated.						
	To Viti	Σ	29b. Signature and title of certifier			29c. License r			29d. Date signe		
				sen /			1244		1/2,	104	
	2		30. Name and address of person w			•					
	9			an, Frostb		a, Frostl	burg, M	id. 2	1532		
	Sta Registi		31. Date filed (Month, Day, Year)	6 2004 Registra	ar's Signature	A. S.					
	negisti	ai	JAR U	0 2004	Bos St.	60000					

		1 - For State Registrar Amend item#23bpo					ealth and M Death	1ental Hy	giene Reg. No.	2004	01510
		1. Decedent's Name (First, Middle, Last)						2. Date of De		. When	3. Time of Death
Physici		Kathleen		Elaine		Cham	bers	JANUAR	Day Y 7.	2004	19:50 M
/Medic Examin		4a. Fecility Name (If not institution, give str	reet and number)		4b. C	ity, Town, or	Location of Death	1 0		County of Death	
EXAMILIE	iei	MEMORIAL HOSPITAL			CIT	MBERLA	ND		Δ	LLEGANY	
Eunaval		5. Social Security Number 6. Sex	7. Age	e (In yrs. last birti	hday) If Un	ider 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Birth	place (State or Foreign
Funeral Director		212-92-7257	M 2⊠F	32	rs. Mont	hs Days	Hours Min.	(Month, Di 05/19/	1971		intry) v land
		Usual Residence of Decedent									
ylan		10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
Mar.	ţō	MD Allegan	У	(Cumber	land					TXXYes 2 ☐ No
r 284	Director	10e. Street and Number			10f.	Žip Code			10g. Cit	izen of What Cou	intry?
3a o		1942 Durham Driv	e			2150	2		US	A	
ms 2	Funeral	11. Marital Status	2. Was Decedent	Ever in U.S.	13. Was De	ecedent of Hi	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No)-	14. Race - Amer	
or Ite	Ē	1XXNever Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2X☐	No				r Hicari, etc.)		Black, White	, etc.
all, o	þ	3 Widowed 4 Drvorced	If Yes, Give Year or Dates:		1 10 10	s 2XXNo	Specify:			Specify:	White
72 ho	Completed	15. Decedent's Educa (Specify only highest grade		16a.	Decedent's U	Jsual Occupa	ation during most of work	in a	16b. Ki	ind of Business/li	ndustry
nin 7	ple	Elementary/Secondary (0·12)	College (1-4or 5	i+)	life. DO NO	T use retired)				
gieni genth	Con	12	4		Nurs	ing St	udent			Medical	
of Hy	Be (17. Father's Name (First, Middle, Last)					18. Mother's Nam				
Ald b Aenta rked tice	70 E	Gerald	Freema	n Cl	namber	S	Maria	Th	eres	e k	Coenig
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28e-f show any injury or other traumatic event, the Medical Exaculties must be collised at once.		19a. Informant's Name/Relationship (Type	e, Print)	19b.	Mailing Add	ress (Street a	and Number or Rur	al Route Numb	er, City o	r Town, State, Zi	ip Code)
alth a		Gerald Chambers /	father	19	942 Du	rham D	rive, Cur	mberlan	d. M	aryland	21502
f Hei f Hei item othe		20a. Method of Disposition		20b. Place of		Name of		Date		ocation - City or T	
age ento ento y or		1 ☐ Burial 2 🖟 Cremation 3 ☐ Rei '4 ☐ Donation 5 ☐ Qther (Specify)	moval from State		,		ory 01/0	9/2004	Cu	mberland	I. MD
artmoortar		21. Signature of Funeral Service Licenses	, ,								Home, P.A.
Depariment of the post of the		A.J. P. (V	100	10000	1000		atur Str				
II CALO		23a. Part1. Enter the disease, or complication	ations that caused	the death. Do n						zanc, m	Approximate
		shock, or heart failure. List only one Immediate Cause (Final	cause on each li	ne.		en.c				-	Interval Between Onset and Death
Physician		disease or condition resulting in death)		ENCEPHA		Y					1 WEEK
/Medical Examiner			Due to (or as	a consequence of	of):						
107		Sequentially list conditions, b.	Due to for as	a consequence o	-61·						
Si &	lner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence o)i).						
and tran-	Examln	that initiated events c. resulting in death) Last	Dua to for as	a consequence of	n().						
cate be executed physician and the burial-transit			000 10 (01 23	a consequence o	<i>.</i>						
ate b hysic the b	dlcal	d.									
w requires that the death certific been signed by the attending p should be detached for use as		IF FEMALE:									
th ce tend	an	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome 1☐Live birth	of pregnancy 2 Fetal death	3 □Ectop	ic pregnancy				23d. Date of deliver Month	very Day Year
he al	sici	1 ☐ Yes 2 📉 No	4☐Pregnant at 9☐Unknown	time of death	5 Other	(specify)					
at the by t	Physician/Me	9 Unknown						1			
es th gned	by	Part II. Other significant conditions conti	ributing to death b	ut not resulting in	the underlyii	ng cause give	en in Part I.				the cause of death?
en si buld	ed							1	Yes 2	□No 3□Pro	bably 4 MUnknown
s be	Completed							24a. Was		24b. Were aut	opsy findings available ompletion of cause of
rhe ite ha	E							auto perf	ormed? 2 No	death?	
infical or, p	0	25. Was case referred to medical					26. Place of Deat			1,3100	20110
s cert	00	examiner?	spital:	ent 2 ER/Ou	tnatient 3	DOA Othe	or			6 ☐Other (Spec	ify)
Phy	: To	27. Manner of Death	28a. Date of Inju	ry 28b. T	ime of	28c. Injury	y at	28d. Describe			.,,,
ding th: Afte	ţ	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year) Ir	njury M	Work	k? Yes 2 □No				
deal ctor	Certification:	3 Suicide 6 Could not be	28e. Place of Inj	ury - At home, fa	rm, street, fac	ctory, office					ral Route Number,
or A after Dire	erti	4 Homicide	building, et	c. (Specity)				City or To	wn, State)	
prite ours ieral filled		29a. Certifier 1 Certifying Physi	ician: To the best	of my knowledge	death occur	rred at the tim	ne, date and place.	and due to the	cause(s)	and manner as	stated
Hos 24 hr Fun stely	edical	(Check only 2 Medical Examinations)		f examination and							
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Med	29b. Signature and title of certifier				29c. License	e number		29d. Da	te signed (Month	, Day, Year)
F 3 F 8		///	15							nuary 8	
3		1/101				D3	6766		J 0.1		, - 1
n Ls		30. Name and address of person who con				DEDT 4:-	m .m o				
	9.012	POONAI, VIK, M.D.,			L, CUM	REKLAN	D, MD 21.	502			
	ate	31. Date filed (Month, Day, Year,)		ar's Signature	4	Spark	11				
Regist	ııaı	JAN 0 9 200	4		1 90	- vin	10				

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			1- For State of Maryland	i / Depa			lental Hygi	•	04 01511
			1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physici		JENNIFER JENKINS CHEEK				JANUARY	7, 200	9ear 04 5:40 P M
5	/Medid Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	or Location of Death		4c. County of	
	LXaiiiii	101	406 SOUTH STREET		CUMBER	T.AND		ALLE	GANY
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,)		Birthplace (State or Foreign Country)
	Director		215-04-3789 1□M 2X F 20	Yrs.	Months Days		SEPT. 3,	1983	MARYLAND
	P .		Usual Residence of Decedent						
	shov	Ļ	10a. State 10b. County 10c. City,	Town or Loc	cation				10d. Inside City Limits
	8a-1	cto		UMBEI	RLAND				1 X Yes 2 □ No
	ours after death with the Marylan rat', or Items 23e or 28e-1 show Extraitmet mast be truffled at	Director	10e. Street and Number		10f. Zip Code		100	g. Citizen of WI	hat Country?
	ath w	<u>ra</u>	406 SOUTH STREET		2150			U.S.	
	er de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. 13. V	Vas Decedent of h Yes, specify Cubi	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, , White, etc.
36	s afte	by F	1 Never Married 2 Married 1	1	☐ Yes 2 No	Specify:		Specify:	WHITE
21215-0036	within 72 hours after death with the Maryland ene. than "naturat", or Items 23e or 28e-1 show to Medical Expripier mat be notified at	pe		16a Dacod	ent's Usual Occup	ation	146	Sb. Kind of Bus	
5	in 72	Completed	(Specify only highest grade completed)	(Give I		during most of work	ing	D. KIIIQ OI DUS	sinessindustry
12	with ene. thar	щ	Elementary/Secondary (0-12) College (1-4or 5+)		JDENT	,		EDIIC	ATION
9	be filed within 72 ho ital Hygiene. id othar than "natui evant, ILe Medical		17. Father's Name (First, Middle, Last)		J. J. L.	18. Mother's Name	(First, Middle, Ma		
<u>a</u>	Mental Mental arked c	To Be	PHILIP CHEEK			JESSIE	DORAN	Į	
Maryland	d 2 should be th and Menta th and Menta ?7 Is marked treumatic ev	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street	and Number or Rura	al Route Number, (City or Town, S	State, Zip Code)
Š	nd 2 lith a 27 is	Ĭ	JESSIE CHEEK / MOTHER	406	SOUTH	STREET,	CUMBERT	.AND	MD 21502
ē,	of Healt itam 2	1	20a. Method of Disposition 20b. Pla	ace of Dispos	sition (Name of		the second secon		City or Town, State
2	8 = 5				MORTAL P	ARK 01/12	2/2004	CUMBERI	LAND, MD
Baltimore,	pemit. Pag Deportment Importent: any njury once.		21. Signature of Funeral Service Licenses		Name and Addre				
ä	permit Deput Import any nj once		Nalla I Mall I	T	IDCHI IDCH	ETIMETOAT I	HOME, P.A		
			23a. Pert1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ente	202 GREEN or the mode of dyin	TE STREET	CUMBERL or respiratory arres	AND, MI	21502 Approximate
					·	•	, , , , , , , , , , , , , , , , , , , ,		Interval Between Onset and Death
	Physician /Medical	8 1	disease or condition resulting in death)	-					4 days
	Examiner		Due to (of as a conseque Ab alom:		_ ` . ~	infectio	2		7 Pour
		ا <u>آ</u>	Sequentially list conditions, b. Due to for as a consecue		cisión	(KIECE)	'h		1 - 1
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.	di	orde				10 is a sec
	al-tra	xai	that initiated events resulting in death) Last C. Due to (or as a conseque						10 9 200
760	ite be executed ysician and ne burial-transit	calE	pro forms	ment	al ret	ar duti	m		10 4 ears
687	3 × 5) Pe	d.						, , , , , , ,
Box (The law requires that the death certificat the has been signed by the attending phy age 2 should be detached for use as th	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnant	су				23d. Date	of delivery
ă	death atter	ciar	in the past 12 months?		Ectopic pregnancy Other (specify)	/		Mont	•
O.	at the de by the a	ys	1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unknown						
Δ.	that		Part II. Other significant conditions contributing to death but not resulti	ting in the un	derlying cause giv	en in Part I.	23e. Did toba	cco use contrib	oute to the cause of death?
Records,	uires 1 sign	d by	Cerebral palsy - spart	x 90	adupt	eqia	1 ☐ Yes	2 No 3	B□Probably 4□Unknown
õ	w require been signal	Completed	Costo an based selle	0	0. 5001	T.e.	24a. Was an	24h W	ere autopsy findings available
Re	The lay	Ę	colo por como por porto	UX_	CX 1JEGJ		autopsy	pri	or to completion of cause of ath?
		မ Co	25. Was case referred to medical					10	☐Yes 2☐No
of Vital	Physician: this certificanal director,	00	examiner?	700	3 DOA Oth	26. Place of Death			
o	Phys r this ral dir	5		:H/Outpatient 28b. Time of	3 ☐ DOA 28c. Injur	4 Nuising nor	me 5 🗷 Residenc 28d. Describe how		
o	ding I h. After funer	Į Į	Natural 5 Pending (Month, Day Year)	Injury	Wor				-
Division	or Attending after death. Director: After in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At hom	ne. farm. stre			28f. Location (Stree	et and Number	or Rural Route Number,
ō	after of Direct	erti	4 Homicide determined building, etc. (Specify)		,		City or Town, S	State)	,
	To tha Hospital or within 24 hours afte To tha Funaral Dir completely filled in		29a. Certifier 12 Certifying Physician: To the best of my knowle	ledge, death	occurred at the tin	ne, date and place.	and due to the caus	se(s) and mann	ner as stated.
	a Ho a Fui etely	Medical	(Check only 2 Medical Examiner: On the basis of examinatio one)	on and/or inv	estigation, in my o	pinion, death occurre	ed at the time, date	and place, an	d due to the cause(s)
	To tha within 2 To tha complet	Me	29b. Signature and title of certifier		29c. Licens	e number	29d	. Date signed ((Month, Day, Year)
	11		Muska Da Tar Ja	Jane.	17	8222		1/0/	04
1,	1 [30. Name and address of person who completed cause of death (Item 2	23a) (Type F		J J J-9		, 1 0 7 0	/_/
Ď	11/08		A	_		ene St. C	inhe la	ul m	0 21502
	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signatur		1		/ t-		
	Registr		JAN 0 \$ 2804	D,	Sparks	/			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician 2004 2:00 A.M. ROSE BERRY CHAYES JANUARY /Medical 4b. City. Town, or Location of Death 4c. County of Deeth 4a Fecility Name (If not institution, give street and number) Examiner HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 1□M 2⊠F 125-07-6778 Yrs. 96 Director TULY 10. 1907 PENNSYLVANIA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours aftar deeth with the Maryland rent of Health and Martal Hygiene.
ant: if item 27 is marked other than "hatural", or items 23a or 28a-f ahow urry or other than "hatural", and them 23a or 28a-f ahow urry or other traumatic event, The Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 □ No Directo MARYLAND MONTGOMERY ROCKVILLE 10f. Zip Code 10a. Citizen of What Country? 10e Street and Number 6121 MONTROSE ROAD 20852 Funeral U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify. Specify: WHITE Completed by 3 ☑ Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 5+ OWN HOME 17 Father's Neme (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JACOB STARK **ESTHER** KOFF 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) DR. F. NORMAN BERRY/SON 6105 DURBIN RD., BETHESDA, MARYLAND 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or c 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) NATIONAL CREMATORY 1/2/04 FALLS CHURCH, VIRGINIA 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 21. Signature of Funeral Service Licensee 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** OCARDIA INFARCTION Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Be Completed by Physician/Medical Examiner or Attending Physician: The law requires thet the death cartificate be executed igned by the ettending physician and be detached for use es the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 1 No 3 Probably 4 Unknown MENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1010 1 ☐ Yes 2 ☐ No 1 J Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No this nours aftar deeth.

neral Director: After this filled in by the funeral d 27. Mennef of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 rifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death (Item 23e) (Type, Print) 30. Name and address of bers ROCKVILLE, MARYLAND 20852 6121 MONTROSE ROAD, A. COMPTON 31. Date filed (Month, Day, Year) JAN 0 7 2004 32. Degistrar's Signature State Registrar

DHMH 16 Rev 6/95

			1 - For State Registrar	State of Maryland		artment of F			ene 2001	+ 01514
	Physici /Media		Decedent's Name (First, Middle, Last) AUGUSTA	THELMA	COTT	MAN		2. Date of Death Month Jan.	Day Year 4 . 2004	3. Time of Death 7:02 P M
	Examir Funeral Director		4a. Facility Name (If not institution, give s $\frac{17060 \text{ King Jame}}{5. \text{ Social Security Number}} \text{ 6. Sex} \\ 174-26-3520 ^{1\square}$	es Way #61	ast birthday)	Gaith	r Location of Deat ersburg If Under 24 Hrs Hours Min.	8. Date of Birth		
	the Maryland 28e-f show	rector	Usual Residence of Decedent		Gait	nersburg	J.		g. Citizen of What Co	10d. Inside City Limits 1X□ Yes 2 □ No
36	rs after death with r, or items 23e or cardinal must be	by Funeral Director	17060 King Jame 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Øivorced	es Way #611 12. Was Decedent Ever in U.: Armed Forces? 1		208 Was Decedent of H If Yes, specify Cuba			U • S • A	A •
Maryland 21215-0036	ed within 72 hou ygiene. her than "natural it, tre Medical E	Be Completed I	15. Decedent's Education (Specify only highest grade Elementary/Secondary (0-12) 6 th	pation	(Give	dent's Usual Occup kind of work done of DO NOT use retired DOMEST	during most of wo	rking	6b. Kind of Business/	ndustry
ıryland	should be fill of Mental H marked ott matic even	To Be	17. Father's Name (First, Middle, Last) Robert Butler 19a. Informant's Name/Relationship (Ty)		19b. Mailir	na Address (Street	Ru	me (First, Middle, Ma th Dixon		io Code)
Baltimore, Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importents: If item 27 is marked other than "natural", or items 23e or 28e-f show amounts: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other treumatic event, the Medical Exercities mail be nullised at once.		Jacqueline Dobb 20a. Method of Disposition 1	emoval from State Lir	1352 ace of Disponentery, crem	O Haywol sition (Name of natory or other place Mem Cer	rth Dr n. 1/1	Potomac, Date 20 2/2004 S	MD 2085 C. Location - City or Siutland, uneral I	5 4 Fown, State MD
Ba	permi Depa Impo any ir		23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the death	1	246 N. I	Washing	ton St F	Rockville	Approximate Interval Between
8760,	The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the law requires the law requirements the law requirements the law requires the law requirements the law req	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfudiate cause. Enter Underfudiate Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to	rence of):	CULAR AG	CCIDENT	N		Onset and Death
.O. Box 6	that the death certificated by the attending poor	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnal 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
rds, P.	iw requires that s been signed to should be deta	by	Part II. Other significant conditions con Diabetes Melle		Ilting in the u	nderlying cause give	en in Part I.		cco use contribute to	the cause of death?
al Reco	iician: The law re certificate has be rector, page 2 sho	Completed		ıropathy					prior to death? ☐ Yes	opsy findings available ompletion of cause of
Division of Vital Records,	ding Phys T. After this funeral di	ation; To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		ER/Outpatier 28b. Time of Injury	Worl	er: 4 ☐ Nursing H	ath (Check only one) Iome 5 Residence 28d. Describe how	ce 6 □Other (Spec	ify)
Divis	pitel or Attene ours after death erel Director: illed in by the	Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify)			City or Town,		
)	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical	(Check only 2 Medical Examination) 29b. Signatur and little of certifier	icitian: To the best of my knowner: On the basis of examinat and manner stated.	ion and/or in	vestigation, in my or	pinion, death occu	irred at the time, date	se(s) and manner as a and place, and due	to the cause(s)
	Sta Registi		31. Date filed (Month, Day, Year) JAN 0 9 200	32. Registrar's Signat	ure &	Sporks	/		208	18

			1 - State AMEND ITEM #2	State of Ob PER FH G8	Marylar 328 2/1 0	nd / Depa 0/04 G e	artment rtificate	of He	ealth a Death	ınd M		giene) (004	015	15
			Decedent's Name (First, Middle,								2. Date of Dea	ath	- · · · · ·	3. Time of I	Death
	Physici /Medic		Charles F. Cro	tty						1	January	J 3, 20	Year)04	1330	М
	Examin		4a. Fecility Name (If not institution,	give street and numb	er)		4b. City, To	wn, or	Location o	f Death			nty of Death		
			Shady Grove Ad				Rocky						tgome		
	Funeral			. Sex 7. 1 X M 2 □ F		last birthday) Yrs.	If Under 1 Months [Year Days	If Under a	Min.	8. Date of Birt (Month, Day	v. Yeer)	Cou	place (Stete or ntry)	Foreign
	Director		723-10-6492 Usual Residence of Decedent	21	72	713.					July 2	, 1931	New	York	
	land ow		10a. State 10b. County	1 11 11 11 11 11 11 11 11 11 11 11 11 1	10c. Ci	ty, Town or Lo	ocation							10d. Inside City	y Limits
	Many Figh	to	Maryland Montgo	mery	Pot	omac								1 Tes	2 X No
	or 28s	Director	10e. Street and Number				10f. Zip C	ode				10g. Citizen o	f What Cou	ntry?	
	th wit	a	11722 Enid Driv	e			2085	4				United	Stat	es	
	within 72 hours after death with the Maryland ene. than *naturel', or itema 23e or 28e-f ehow he Medical Examiner must be notified a	Funeral	11. Marital Status	12. Was Decede Amed Force	967		Was Deceder	nt of His Cubar	spanic Orig	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)		ace - Ameri lack, White		
36	s afte , or li	by Fu	1 ☐ Never Married 2 📉 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give			1 ☐ Yes 25	No 5	Specify:			Spec	ify:		
Ö	hour turel	pa pa	15. Decedent's	Year or Date	s: Wa		dent's Usual (Jeenna	tion			16b. Kind of		ite	
15	in 72	Completed	(Specify only highest	grade completed)		(Give	kind of work	done di	urina most	of working	ng	IGD. KIIIG OI	DUSITIOSSII	idustry	
7	with jiene.	E	Elementary/Secondary (0-12)	College (1-4 4	or 5+)	Infor	mation	Sy	stems	Ana	lyst	Genera	l Ele	ctric	
ğ	Hyg othe	Be C	17. Father's Name (First, Middle, La	est)					18. Mothe	r's Name	(First, Middle,	Maiden Sum	ame)		
ılar	uld by Aenta rked ric ev	To E	Leo A. Crotty						Hele	n Fa	iley				
Maryland 21215-0036	and l		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (S	Street a	nd Numbe	r or Rura	Route Numbe	r, City or Tow	n, State, Zij	o Code)	
	and sealth TI 27		Frances D. Cro	tty/Wife		-		2.00	ive,	Poto	mac, Ma				
ore	H ite		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	☐Removal from St.	20b. F	Place of Disponentery, crei	natory or othe	of er place) B	eeem		20c. Location			
Ë	Pag trment tant: jury			4 Donation 5 Other (Specify) Cemetery 2004-1/08/0									c, Ma	ryland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than *naturel; or itema 23a or 28a-1 show eny injury or piher traumatic event, the Medical Exeminer must be notified all once.		21. Signature of Funeral Service Li	Jeny	, моо	R	2. Name and A OCKVIL OCKVIL	le.	Inc.	300	West M	lontgom	ey Fu hery A	neral i	iome/
S	Physician /Medical Examiner	ler	23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Security list conditions if any, leading to immediate	a. Metast Due to (or	h line.	QVCINOV quence of):								Approximate Interval Betw Onset and D	eath
68760,	death certificate be executed e attending physicien and of for use as the burial-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	c. Due to (or	as a consec	juence of):									
.O. Box	that the death certific ed by the attending p detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		n 2 ∏ Feta it at time of c	Ideath 3	Ectopic preg Other (spec	,					ate of deliving		ear
rds, P	The law requires that the No has been signed by the bage 2 should be detache	by	Part II. Other significant condition upper gastrointe	1 . ()	th but not res	1	nderlying cau	se givei	n in Part I.			bacco use co es 2 🗆 No	ntribute to t 3 ☐ Prot	he cause of de pably 4 Wir	
Vital Record	aw re	Completed	liver failure			-					24a. Was			ppsy findings a	
m	: The law cete has page 2 a	E	acute verial for	iluve							autop perfor 1 Yes		death?	mpletion of ca 2□ No	038 01
ita	ysician: Th is certificete director, pag	ВеС	25. Was case referred to medical examiner?		/				26. Place	of Death	(Check only of				
of V	d is	2	1 ☐ Yes 2 🗷 No	Hospital: 1 Inp	atient 2□	ER/Outpatier	nt 3 DOA	Other	r: 4□ Nur	rsing Hom	ne 5 🗆 Resid	ence 6 □O	ther (Specil	(y)	
u o	ding P. h. After ti funera	ü	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of (Month,	Injury Day Yeer)	28b. Time o Injury		. Injury Work	at ?	2	8d. Describe h	ow injury occu	urred		
sio	Attending Physician: r death. ector: After this certific by the funeral director.	cati	2 Accident investiga 3 Suicide 6 Could no	t be			М		es 2 N						
Division	tal or Attenus after death	Certification;	4 Homicide determin	289. Place of	Injury - At h , etc. <i>(Specil</i>	ome, farm, str fy)	eet, factory, o	office		2	8f. Location (S City or Tow	treet and Nun n, State)	nber or Rura	al Route Numb	er,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physicien: To the bastand manne	s of examina	owledge, deat ation and/or in	h occurred at vestigation, in	the time my opi	e, date and inion, deat	d place, a h occurre	nd due to the d id at the time, o	ause(s) and n late and place	nanner as s , and due to	tated. the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. L	cense	number		2	29d. Date sign	ed (Month,	Day, Year)	
١ .	121		Pros	1 4 5	280	no	- D	y.	308	73		JANUA	my or	1, 200	4
1	IAI,		30. Name and address of person wi	no completed cause	of death (Iter	n 23a) (Type,	1						•	10	•
			GEDRIGE A SOTOS, N	10 9707 M	EDICAL	CENTER	L DAINE	, #	300	ROCE	EUILLE,	MO -	20850)	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 5 2		istrar's Signa	ature &	Spar	Kr	1.						

-			1 - For State Registrar	State of Maryland /		ertment of tificate of				ene J. No.2 0 (***	01516
	Physici /Medic		1. Decedent's Name (First, Middle, Last) JOYCE MAXINE	CONLEY					Date of Death Month JAN 16	Day 200	/eer / ₄	3. Time of Death 5:48P M
	Examin		4a. Fecility Name (If not institution, give st. Civista Medica	1 Center		La	n, or Location o				rles	
	Funeral Director		5. Social Security Number 6. Sex 254-42-8797	7. Age (In yrs. last	3 Yrs.	If Under 1 Ye Months Day		Min. DE	Date of Birth (Month, Day, Y C • 5 • 1	930	Countr TEN	ace (State or Foreign ry) N •
	a-f show	ctor	10a. State 10b. County MARYLAND PRINCE	GEORGE 10c. City, To	own or Lo		CCOKE	EK			10	d. Inside City Limits 1 ☐ Yes 2 ☐ No
	uth with the 23s or 28 ust be no	rai Director	10e. Street and Number 14910 SCHALL ROA	D		10f. Zip Code	20607			U.S	. A.	
920	d within 72 hours after death with the Maryland liene. r than "natural", or items 23a or 28a-f show the Medical Examinat must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1579es 2 No ARMY If Yes, Give Year or Dates: 1950-5	Y 1	Vas Decedent of Yes, specify C			Yes or No- an, etc.)	14. Race Black Specify:	White, et	
Maryland 21215-0036	within 72 ho ene. than "natur be Medical	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ition 16	6a. Deced (Give I life. L	ent's Usual Oci kind of work do DO NOT use ret	ne during mos tired)			6b. Kind of Bus		,
land 2	be filed ital Hyg id other avant,	To Be Co	17. Father's Name (First, Middle, Last) KERMITT ROSE	VELT REED	100	DUCKY	18. Mothe	er's Name (Fi	rst, Middle, Ma	iden Sumame,)	Jr ED•
	ges 1 and 2 should t of Health and Men if Item 27 is marks or other traumatic	- 1 0))	19a. Informant's Name/Relationship (Type RICHARD F • CONLE	Y-SON 1	1913	MICHA	EL RD	• WA	LDORF	City or Town, S	AND	20601
Baltimore,	permit. Pages 1 Department of He Important: If Iter any injury or oth		20a. Method of Disposition Disposition 2 Cremation 3 Re	noval from State Ceme	MEM	Name and Ad	CNS 1 dress of Facility FUNE	RAL S	4 W	E,P.A.	•	m, State
**	Physician /Medical Examiner	6	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Death cause on each line. Due to (or as e consequence	tit							Approximate Interval Between Onset and Death
760,	be executed sician and burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dispase or lining) that initiated events resulting in death) Last	Due to (or as a consequence								
.O. Box 68	The law requires that the death certificate Lite has been signed by the attending physicage 2 should be detached for use as the b	Physician/Medical	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 DNo 9 Unknown	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown	ath 3 🗌	Ectopic pregna Other (specify)				23d. Date Monti		y Day Year
rds, P.	v requires that been signed t should be deta	ed by PI	Part II. Other significant conditions cont Atrial fibri					l. ——				cause of death?
Il Records,		Completed by	throughosis	coronary	art	ery c	lisecie	se	24a. Was an autopsy performe	pri d? de	or to comp ath?	sy findings available pletion of cause of
Division of Vital	To the Hospital or Attending Physician: The within 24 hours atter death. To the Funeral Director: After this certificate completely filled in by the funeral director, page.	To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		Outpatient b. Time of Injury	28c. Ir	Othor	ursing Home 28d. No	Describe how	ce 6 Other		
Divis	vital or Attendurs after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)					City or Town, S			
	To the Hospital within 24 hours at To the Funeral Completely filled it	Medical	29a. Certifier (Check only one) Certifying Physi Medicel Examina 29b. Signature and title of certifier	cien: To the best of my knowled er: On the basis of examination and manner stated.	dge, death and/or inv		e time, date an ny opinion, dea ense number	nd place, and ath occurred a		se(s) and manre and place, an		
)	Twin Solo		Muchall	I Suitely V	10	H.	-00424	445		sucer y		
3.	Sta	te	30. Name and address of person who con Michael A Pime 31. Date filed (Month John Year) ZUL	ntel_MD 601	Post		ce Roa	ad Ste	e 1A W	aldorf	, M	D 20602
	Registr		### 3 x 5	1	A Partie							

			1 - For State Registrar	State of Ma	arylan		artment tificate			ind M		giene Reg. No. 2	004	01517
	Physici /Medio		1. Decedent's Name (First, Middle, Last,	Derby							2. Date of Dea Month	Day	2004	3. Time of Death
	Examir	100	11110	redical (inte	Sast birthday)	4b. City, T	Napo			8. Date of Birtl	An	ne Ar	nde (lace (State or Foreign
	Funeral Director			V-	75	Yrs.		Days	Hours	Min.	JAN 17	1928	PA	try)
	death with the Maryland ims 23a or 28a-f show f must be notilled at	ctor	10a. State 10b. County MD TALBO	Γ	10c. Cit	y, Town or Lo								0d. Inside City Limits 1 X Yes 2 No
	ath with the 23a or 28	Funeral Director	10e. Street and Number 7290 KATHY STREET				_	601					USA	
36	be filed within 72 hours after death with the Marylar ital Hygiene. Id other than "natural", or itams 23s or 28s-f show of other than "natural", or itams 23s or 28s-f show event, the Medical Examinet must be notified at	by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐XI If Yes, Give Year or Dates:			Was Decede fYes, specif 1 ☐ Yes 2		spanic Origin, Mexican Specify:	gin? (Spe , Puerto	city Yes or No- Rican, etc.)		Race - Americ Black, White, ecify: WHI	etc.
215-00	within 72 hours after 6ne. than "natural", or Ita ne Med cal Examine	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i> College (1-4or 5	5+)	(Give life. I	dent's Usual kind of work DO NOT use	done di retired)	uring most	of worki	ng		of Business/Inc	dustry
Maryland 21215-0036	Ibe filed within nat Hygiene. ad other than event, the Mer	Be	12 17. Father's Name (First, Middle, Last)	0		H0	OMEMAK				(First, Middle,	Maiden Su	N HOME	
Maryle	s 1 and 2 should be f Health and Menta frem 27 is marked other traumatic ev	J.	JOHN CUNNANE 19a. Informant's Name/Relationship (T) JOAN DERBY/DAUGHT						nd Numbe	r or Rura	MACALIN I Route Numbe STON, M	r, City or To		Code)
Baltimore,	e = 5		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)		0	Place of Dispo cemetery, crem	sition (Name natory or oth	e of her place	9)	C	3-2004	20c. Locat	ion - City or To	
Balti	permit. Pac Departmen Importent: any njury once.		21. Signature of Funeral Service Licens	MEZC	EZ	> F1	Name and ELLOWS	Address HI HARI	s of Facility ELFEN RISON	BEIN ST	& NEWN	AM FU MD 2	NERAL H	
4	Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	ications that caused ne cause on each li	the deathne.	h. Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Opset and Death
	/Medical Examiner	J6	resulting in death) Sequentially list conditions,	Due to (or as	a conseq	uence of):								days
8760,	icate be executed physician and s the burial-transit	lical Examiner	Sequentially list conditions, I any, leading cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a conseq	uence of):	Line	_ \	3	den	**			years.
.O. Box 68	the death certify y the attending iched for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	death 3	Ectopic pre Other (spe				******	23d	. Date of delive Month	ry Day Year
rds, P	signed d be de	by	Part II. Other significant conditions co	ntributing to death b	ut not res	ulting in the u	nderlying ca	use give	n in Part I.			es 2 N		e cause of death? ably 4 \(\sum \)Unknown
Vital Records,	The ate h page	Completed	hyperters	ion							24a. Was a autop perfor 1 Yes	sv	4b. Were autoportion to condeath? 1 Yes	osy findings available inpletion of cause of
of Vita	tending Physiclan: Theleath. tor: After this certificate the funeral director, pag	To Be (1 Yes 21 No	Hospital: 1 Inpatie		ER/Outpatier	_	-	E 4 □ Nu	rsing Hor	(Check only on the 5 Resid	ence 6		")
Division (tending leath. tor: After the fune	Certification:	27. Mame eath atural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Inju (Month, Da 28e. Place of Inju	y Year)	28b. Time of Injury	М		at ? ′es 2 □ !	No	28d. Describe h			l Route Number,
Div	To the Hospital or Attend within 24 hours after death To tha Funeral Director: / completely filled in by the f		4 Homicide determined 29a. Certifier 1 Certifying Phy	building, et	c. (Specif	(y) 			e, date an		City or Tow	m, State)		
	To the Ho within 24 h To the Ful completely	Medical	(Check only 2 Medical Exemination 29b. Signature and little of certifier	ner: On the basis o and manner st	f examina ated.	ation and/or in		License		th occurr			igned (Month, I	
	r ≯⊨ ö		>//N.C. C	ompleted cause of	leath (Iten	n 23a) (Tune	Print)	>5	392	-7		1/2	-104	
*5			Michael (ex	22. Registr	SCX	21 m	المارد	FL	Part.	wc	VA	Vogo!	MI	21401
	Sta Regist		31. Date filed (Month, Day, Year)	4 Deser	A.	Ance	BI							

			1 - For State Registrar	State of Maryla	ınd / Depa		Health and		ene 2001	01518
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last) VERNON R. DONOHO 4a. Facility Name (If not institution, give second)	street and number)	/	4b. City, Town,	or Location of Deal	th	Day Year 05 2009 4c. County of Dea	th
	Funeral Director		5. Social Security Number 220-12-0829 Usual Residence of Decedent		s. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth	9. Bir	thplace (State or Foreign buntry)
215-0036	be filed within 72 hours after death with the Maryland all Hygiene. Id Hygiene. Id other than "natural", or itema 23s or 28s-1 show other than "natural", or itema 23s or 28s-1 show event, it a Medical Examinat must be notified at	Completed by Funeral Director	10a. State 10b. County MD WICOMI 10e. Street and Number 5829 HAMMOND SCHOO	L ROAD 12. Was Decedent Ever in Armed Forces? 15 Yes. Give Year or Dates:	16a. Deced	10f. Zip Code 21804 Vas Decedent of i Yes, specify Cub	pation during most of wo	Specify Yes or No- to Rican, etc.)	USA 14. Race - Ame Black, Whit Specify: WH	encan Indian, e, etc. ITE
Maryland 21215-0036	s 1 and 2 should be filed w if Health and Mental Hygier itam 27 Is markad other ti other traumatic event, IL	To Be Cor	6 17. Father's Name (First, Middle, Last) WILLIAM E. DONOHO 19a. Informant's Name/Relationship (Ty)	рө, Print)			MARY E.	me (First, Middle, Mai		
a)	permit. Pages 1 and 2 Department of Health Important: If itam 27 any injury or other tre		GLORIA MARVEL DONO 20a. Method of Disposition 1 X Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. nature Funeral Service Licenees	emoval from State	Place of Disposementary, cremetery, cremeter	sition (Name of natory or other pla L MEM. G. . Name and Addre	DNS. 01-0	08-2004 SAI UNDS FUNER	Location - City or LISBURY . 1	Town, State
/60,	te be executed /Medical /Medical examiner	cal Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	ath. Do not enter O O () equence of): C equence of).	er the mode of dyi	ng, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death (U) ()
O. BOX 68	that the death certificate led by the attending phy: detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2☐No 9 ☐ Unknown	3c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3 🗌	Ectopic pregnanc Other (specify)	У		23d. Date of deli Month	ivery Day Year
ords, P	requires	ompleted by Pl	Part II. Other significant conditions con	tributing to death but not re	esulting in the un	derlying cause giv	ven in Part I.	1 ☐ Yes	2⊠No 3□Pr	the cause of death?
Ï	Physician: The law i this certificate has b ral director, page 2 st	Be Comp	25. Was case referred to medical examiner?				THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER.	24a. Was an autopsy performed 1 Yes 2	prior to death?	topsy findings available completion of cause of
JIVISION OF	Phy rathis	Certification; To	27. Manner of Death 1 Matural 2 Accident 3 Suicide 4 Homicide	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At building, etc. (Spec	□ ER/Outpatient 28b. Time of Injury home, farm, streetify)	28c. injui Wol 1 🗆	y at	ome 5 Residence 28d. Describe how in 28f. Location (Street City or Town, St	njury occurred and Number or Ru	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Medical Ce	29a. Certifier Check only one) Certifying Phys 2 Medical Examin	ician: To the best of my kr lef: On the basts of examinand manner stated.	nation and/or inv	estigation, in my c	e number	rred at the time, date	e(s) and manner as and place, and due	to the cause(s)
Q	Sta Registr		30, N, me and address of person who cor AUL -LEUR 31. Date filed (Month, Day, Year)	mpleted cause of leath (lite M D 3 6 5 32. Regir Irar's Sign	MP em 23a) (Type, F Ten nature	Print) IN ST	24872 Poco.	MorceC	16/04 Equs	21857

		1 - For State Registrar	State of	Marylan		artment rtificate			nd Me	ental Hyg	iene g. No. 2 ()	104	01519
Physi	cian	Decedent's Name (First, Mic James Lyle								2. Date of Deat Month	Day	Year	3. Time of Death
/Med	dical	4a. Fecility Name (If not institut		her)		4b. City, T	own, or Lo	cation of		Jan.	4c. County	004 of Death	2:40 a [™]
Exam	iner	13 Madary Ro					verna		_		Ann	e Aru	ındel
Funan		5. Social Security Number		7. Age (In yrs. i	last birthday)	If Under 1	Year If	Under 24	4 Hrs.	B. Date of Birth			place (State or Foreign
Funera		722-12-6986 Usual Residence of Decedent	1 ∑ M 2□F	75	Yrs.	Months	Days H	Hours	Min.	(Month, Day, Apr. 9,		Cour	MD
Maryland -f ehow	tor	10a. State 10b. Cour MD Ann	e Arundel	10c. City	y, Town or Lo		Sever	na P	ark			1	1 ☐ Yes 2 X No
r 288	Director	10e. Street and Number				10f. Zip C	Code			1	0g. Citizen of	What Cour	ntry?
h with	<u>=</u>	13 Madary Ro	ad				211	146				USA	1
Ind 21215-0036 be filed within 72 hours after death with the Maryland hall Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examinar must be required at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ M 3 □ Widowed 4 □ Divord	If Yas, Give	ces? 2 ∐ No 9 т.π.тт		Was Decede If Yes, specif 1 Yes 2		anic Origin Mexican, (Specify:	n? (Spec Puerto R	ify Yes or No- ican, etc.)		ck, White,	can Indian, etc. Thite
21215-0036 sod within 72 hours aff rgiene. er than "natureit, or the Medical Exami	Completed		ent's Education hest grade completed)	4or 5+)	(Give	dent's Usual kind of work DO NOT use	done duri	on ing most o	of working	9	16b. Kind of B	usiness/In	dustry
212 d withi giene.	E	12	,		Tele	ephone	Comp	oany '	Work	er	Com	munic	cations
Maryland 212- Id 2 should be filed within the and Mental Hygiene. 77 to marked other than traumatic event, the M	To Be (17. Father's Name (First, Midd George Albin					18			(First, Middle, 1 lizabet			
0 2 2 2		19a. Informant's Name/Relation Joan Dick/Wi			11	_	_	_		Route Number a Park,			Code)
Baltimore, M sermit. Pages 1 and 2 Department of Health mportant: If Item 27 nny injury or other tr		20a. Method of Disposition 1 Surial 2 Crematic 4 Donation 5 Other	n 3 🗆 Removal from S	State C	Place of Disponentery, creatern Hav	sition (Name	e of ner place)		on. 1	te	Glen Bu	- City or To	
Baltimol permit. Pages Department of Important: If It	- SDCe	21. Signature of Juneral Servi			Ba	Name and arrance 5 Gov	Address of & S	of Facility	P.A	. Sever	na Parl	k Fun k, MD	meral Home 21146
Nedica We be executed Wiscian and No burial-transit	al	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1 c		and					Conc	2:-		18 an on This
Sox 68 sth certifica ttending ph or use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		irth 2 ☐ Feta ant at time of d	Ideath 3[⊒Ectopic pre ⊒ Other (<i>spe</i>						ate of deliver	ery Day Year
rds, P.O. It luites that the dean signed by the a lid be detached to	þ	Part II. Other significant cond	litions contributing to de	eath but not res	ulting in the u	inderlying ca	use given i	in Part I.		23e. Did to	_	tribute to t	he cause of death?
Records, The law requires te has been signe	Completed									24a. Was a autops perfor	ned?	prior to co death?	opsy findings available impletion of cause of
	a	25. Was case referred to med	ical				2	6. Place o	of Death	(Check only on	-		
P P P P P P P P P P P P P P P P P P P	on: To B	examiner? 1 Yes 2 No 27. Manner of Death De Natural 5 Per	28a. Date o	npatient 2 of Injury h, Day Year)	ER/Outpatie 28b. Time o Injury	f 28	c. Injury at Work?	t	21	e 5 Teside 3d. escribe ho			(y)
ViSi Atten r deat ector: by the	Certification:	3 Suicide 6 □ Col	uld not be emined 28e. Place building	of Injury - At h	ome, larm, st by)	M reet, factory,		s 2□N		BI. Location (Si City or Town		ber or Rura	al Route Number,
To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical Co	29a. Certifier 12 Certi (Check only 2 Medione)	lying Physician: To the cel Examiner: On the ba and mann	asis of examina	owledge, deal	h occurred a evestigation,	at the time, in my opini	date and ion, death	place, ar	nd due to the c d at the time, d	ause(s) and mate and place,	anner as s and due t	stated. o the cause(s)
c the	Mec	29b. Signature and title of cer				29c.	License n				9d. Date signe		
F 3 F 8		Marry	en bo	est	Son	06	27	7 9.	3 8		To-40	47	8,2004
		30. Name and address of pers	G555	T- M	0. 7	Print)	Aq	406	e-7	rd.	Elea	Bur	8,2004 -aie MD 215
	State strar	31. Date liled (Month, Day, Yo	ar) 32. 5	gistrar's Signa	ature A	Good	į.						

		•	For Stete Registrar	S	tate of	Marylan		artment o			ınd Men		iene g. No.2	004	01520
			1. Decedent's Name (First, Middle	e, Last)								Date of Deat	h Day	Year	3. Time of Death
			Thelma			Mae			Dav	ris	_	nuary		004	8:25 A M
			4a. Facility Name (If not institution	n, give stre	et and numb	oer)		4b. City, Tow	m, or Loc	cation of	f Death		4c. Cou	nty of Death	
			115 East Offu	tt St											
F	uneral		5. Social Security Number	6. Sex							Min. (/	pate of Birth Month, Day,	Year)	Cou	
Di	irector		215-42-4625	1	20.7 1	68	Yrs.				02	/09/19	935	Mary	land
and	3 -					10c. City	y, Town or Lo	cation							10d. Inside City Limits
Maryl	f sho	ō	MD A1	lecan	v		Cumba	rland							1∭Yes 2□No
the	286	Je C	10e. Street and Number	208411	J				de			10	Og. Citizen	of What Cou	intry?
with	30 O	<u>-</u>	115 East Offu	tt St	reet			21	502			ĺ	USA		
death	ms 2	Jer 8	11. Marital Status	12.	Was Deced	ent Ever in U.	S. 13.	Was Decedent	of Hispa	nic Orig	gin? (Specify	Yes or No-			
after a	or les	3	1 ☐ Never Married 2 ☐ Mar	ried	1 ☐ Yes 2	[XNo	1				, rueno micai	11, 610.)		- 95	, etc.
033 ours	EXE	d b	3 ☐ Widowed 4 ☑ Divorces		Year or Dat	es:				poony.				W	
5-6-7-6-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1	dica	ete					(Give	kind of work d	one durin	n ng most	of working		16b. Kind o	f Business/Ir	ndustry
Z igh	P W	ם	Elementary/Secondary (0-12)		College (1-4	lor 5+)	iire.						u.		0.77
Examinor As Design Name (Incat institution, give street and number) 45. County of Death 45. County of	er														
and be for	ed o	Be			Luther	•	Swan	nd o 1							iese
Z John Z	mark	Important: It is marked out of the marked by the attending physician and so should be detached for use as the burial-transit of the straingle							reet and						
Ma	27 is trau							•							0.0
6, - H	Funerel Director: After this certificate has been signed by the attending physician and ely filled in by the funeral director, page 2 should be detached for use as the burial-transit one of the funeral director, page 2 should be detached for use as the burial-transit one of the funeral director, page 2 should be detached for use as the burial-transit one of the funeral director. To Be Completed by Funeral Director					20b. P	lace of Dispo	sition (Name o	of	1					
TO ages	y or				oval from St	ate	-	-		0	1/08/2	004	Bio I	2001.	Maryland
Hit Barton	ortar injur e.					,							_		
B F	e e a		telent (1/1	O and								•		•
			23a. Part1. Enter the disease, o	r complicat	ions that car	used the death	h. Do not ent	er the mode of	dying, s	uch as	cardiac or res	piratory arre	st,		Approximate Interval Between
Phy	Sicient	N I	Immediate Cause (Final	only one o	A 435 OF 64		O PD								Onset and Death
			resulting in death)	a	Due to (o										2400-
Exa	aminer		Out of the first and distant												V
	=	ner	if any, leading to immediate cause. Enter Underlying	, ,	Due to (o	r as a conseq	uence of):								
ocute	ind trans	ami	that initiated events	c											
80, 80,	cian a		resulting in death) cast	ı	Due to (o	r as a conseq	uence of);								
876	ohysic the b	dica		d											· · · · · · · · · · · · · · · · · · ·
× 6	ding p	/Me		230	If yes outco	ome of pregna	incv						224	Date of delia	
Bo aff	atten for u	ian	in the past 12 months?	200.	1 Live bin	th 2 ☐ Feta	Ideath 3								
o 🖁	ched	ysic					04.11	J Othor (speed)	,,						
	ed by detai		Part II. Other significant condit	ons contrib	outing to dea	th but not res	ulting in the u	nderlying caus	e given ir	n Part I.		23e. Did tob	acco use c	ontribute to I	the cause of death?
ds	sign Id be		Ban	wit	-1							1 ⊈ .Ye	s 2 🗆 No	3 ☐ Pro	bably 4 □Unknown
S S	peed	lete										24a. Wasaı	24	b. Were aut	opsv findings available
B B	has ye 2	E D						-			_	autops: perforn	red?	prior to co death?	ompletion of cause of
<u>a</u> :	ficate or, pa		25 Was seen referred to madis:	1					06	Place				1 L Yes	2 No
Sicia	recto	00	examiner?		pital:	nationt 2	EB/Outpatier	3 DOA	Other					Other /Speci	(6v)
o d	ar this eral d						28b. Time o		Injury at	-	-				.97
on ding	. Afte	for	in the state of th	.9	(Month	, Day Year)	injury	М		2 🗆 1	No				
Visi	octor by the	ifica	3 ☐ Suicide 6 ☐ Could		28e. Place o	of Injury - At ho	ome, farm, sti	eet, factory, of	fice					mber or Rur	al Route Number,
5 5	d in	Sert	4 Homicide		Duilding	j, etc. (Specii)	y)					ony or rown	, Siale/		
ospit	unere ly fille														
the H	the Fi	edic	one)				andorm								
10.4	10	Σ	29b. Signature and title of certifi	er //	. 4	. 1									
1	+		· 43	Mer	u My	~		D1	.7565	5			Janua	ry 5,	2004
6	./ X		30. Name and address of person	who comp	leted cause	of death (Item									
11					Jr.	, M.D.				Hig	hway,	LaVal	e, MD	2150	2
					2200	yistiai s Signa	B	Ann	11						
			0,111 0 0 2	, UU T			100	popular contract	die						

			1 - For State Registrar	State of Ma	ryland	-	artment of rtificate of			-	giene Reg. No.	2111		01521
	, Diversity		1. Decedent's Name (First, Middle,	Last)						2. Date of De Month	ath Day	/ Yea		3. Time of Death
	Physici /Medio		Alberto	Diaz						Jan.2	,20	04		3:08a M
	Examin	er	4a. Facility Name (If not institution,	-		3		n, or Location	of Death			County of De		
			Montgomery G 5. Social Security Number		o (In yrs. Ias		Olne		r 24 Hrs.	8 Date of Bir		Montg		
ŀ.	Funeral Director		216-57-0282	1 X M 2 □ F	68	Yrs.	Months Da		Min.	8. Date of Bin (Month, Da 6 / 1 4 /			Country	ce (State or Foreign v)
	P _		Usual Residence of Decedent		40- 01- 1					U/ 1 1/				
	ahow	ř	Md Monto	omery	10c. City, 1		Spring	ä					10d	I. Inside City Limits 1 ☐ Yes 2X No
	the M	recti	10e. Street and Number				10f. Zip Cod				10a. Citi	zen of What	Country	
	3a or	O E	3904 Bel Pre	Road #7			2090					Peru		
	death	ner	11. Marital Status	12. Was Decedent 8 Armed Forces?	ver in U.S.	13. \	Was Decedent	of Hispanic O	rigin? (Spec	cify Yes or No		14. Race - Ar Black, W		
36	be filed within 72 hours after death with the Maryland hal Hyglene. Indocther than "natural", or flams 23a or 28a-f ahow avant, the Medical Examiner must be natified at	by Funeral Director	1 ☐ Never Married 2 ★ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 □ Yes 2 🛣 N If Yes, Give	lo	1	1 X Yes 2□		Per				Whi	
21215-0036	Phour	ted t	15. Decedent's	Year or Dates:		16a. Deced	dent's Usual Oc	cupation			16b. Ki	nd of Busines	ss/indus	stry
2	hin 7%	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5	+)	(Give life. l	kind of work do DO NOT use re	one during mo stired)	st of workin	g				
7	filed within I Hyglene. other than	Соп	12				Clear						g C	ompany
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic avant, the M	0	17. Father's Name (First, Middle, L Manuel Diaz	ast)						(First, Middle, ria P				
2	hould d Mer marke matic	오	19a. Informant's Name/Relationsh	in (Type Print)		19b Mailin	ng Address (Str						Zin C	ode)
<u>8</u>	ulth an 27 is		Olga Diaz/Wi											,Md20906
ē,	f Hea item othe		20a. Method of Disposition		20b. Plac		sition (Name or natory or other			ate		cation - City		
Ê	Page nent o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp				Heave	en 1	1/05/	04	Si	lver	Spr	ing,Md
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked t any injury of other traumatic av once.		21. Signatural Funeral Service L	Jensee L		22 P	Name and Ad PHILIP	D.RIN	NALDI	FUNE	RAL	SERV	ICE	P.A. Md20910
			23a. Part 1/. Enter the disease, or of shock, or heart faiture. List of	complications that caused	the death.							L OPI	A	approximate nterval Between
La .	Pnysician		Immediate Cause (Finat disease or condition		icemi								0	Onset and Death
412	/Medical Examiner		resulting in death)	Due to (or as a	a consequer	nce of):								
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	nted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury				tory I	Failur	60				a	lays
Ć	execu in and ial-tra	Exa	that initiated events resulting in death) Last	Due to (or as a	a consequer	rce of):	icory i	rallul	<u>. C</u>				u	ays
58760,	ficate be executed physician and is the burial-transit	dical		d. Mult:	ilple	Org	an Fa	ilure					d	lays
Box (leath certific attending p	w	IF FEMALE: 23b. Was decedent pregnant	23c. tf yes, outcome								23d. Date of c	delivery	
	death	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown]Ectopic pregna] Other (specify					Month	Da	ay Year
P. O.	res that the de signed by the a be detached f	Phys	9 Unknown							00. 0:4.				41.40
Records,	The law requires that the death certif tte has been signed by the attending page 2 should be detached for use as	by	Part II. Other significant condition	ns contributing to death bu	it not resulti	ng in the ui	nderlying cause	given in Part	1.			_		cause of death?
ပ္ပ	ne law re has bec ge 2 sho	Completed								24a. Was		24b. Were	autopsy	y findings available detion of cause of
	The laste happened	Сош								perfo	rmed?	death	? es 2[
Vita	ilcien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospitat:					e of Death	(Check only o	ine)			
of	Physicien: r this certifica ral director, p	. To	1 ☐ Yes 2 🛣 No 27. Manner of Death	Hospitat: 1 Xinpatie		VOutpatien 3b. Time of	I 3 DUA			e 5 ☐ Resid 8d. Describe h			oecify)	
on	th. Th. After	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day	Year)	Injury		njury at Work? 1 □ Yes 2 □		bu. Describe i	IDJI II WOI	y occurred		
Division of Vital	or Attending Ph ifter death. Director: After th in by the funeral	Certification;	3 Suicide 6 Could not	ot be and Black of Inju	ury - At home c. (Specify)	e, farm, str	eet, factory, offi	ice	21	Bf. Location (S City or Tox			Rural R	Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this cartifica completely filled in by the funeral director.	ledical Ce	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best of xaminer: On the basis of	of my knowle	edge, death	occurred at th	e time, date a	nd place, ar	nd due to the	cause(s)	and manner	as state	ed.
	the h	Med	29b. Signature and little of certifier	and macher sta	ted			ense number				e signed (Mo		
1	7		A N	() 6	(12	(M)		-	391					**
	2		30. Name and address of person w	who completed gause of de	eath (Item 2)	3a) (Type.	Print)	1400	7/1		701	(12	, 2004
24			CHUKWUE 31. Date filed (Month, Day, Year)	M NWO 32. Registra	54,	MB.	18	1014	claric	HILL	il j	DR. CVA	ity	, 2004 , MD
	Sta Registi	100	JAN 09		war.	19	Span	KN						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12:40 am 5, 2004 January Eugene G. Donati /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Montgomery Olney 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 X M 2 □ F 73 March 10, 1930 Pennsylvania Director 186-22-1675 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location f show 10a State 10b. County ral, or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Directo 01ney Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20832 USA 3636 Queen Mary Drive death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ZYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite any injury or other traumatic event, tra Medical Examinance. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Korea 1 ☐ Yes 2 ☒ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Orchestra Leader Music 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Guido Donati Pia Boggi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley H. Donati/ Wife 3636 Queen Mary Drive, Olney, MD 20832 20b. Place of Disposition (Name of cometery, crematory or other place)

Gate of Heaven
Cemetery

22. Name and Address of Facility Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State January 10 * 4 ☐ Donation 5 ☐ Other (Specify) 2004 Silver Spring, MD 21. Signature of Funeral Service Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Jues 1 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Pnysician a Respiratory Failure /Medical Due to (or as a consequence of): **Examiner** _{b.} Pneumonia Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No 9 Unknown been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Hypertension, Chronic Obstructive Pulmonary Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an iis certificate has director, page 2 autopsy performed? 1 Yes 2 🛭 No To the Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Diractor: , completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00058542 Dr. Liluic Heine -Muse cita mic-5, 2004 MAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Libus Heinz-Momckovic M.D. 11501 Georgia Avenue, #515, Wheaton, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 7 2004 Registrar

			1 - For State Registrar	State of I	Maryland		artment of H		ind M		ene 2 0	OĻ	01523	3
			1. Decedent's Name (First, Middle,	Last)						2. Date of Death Month	Day	Year	3. Time of Death	
			Marianthe S.	Dracopou	ılos					January	1, 200	04	11:25 AM M	
							4b. City, Town, or		f Death		4c. County			
									14 Ura		Montg		·	_
94	Funeral Director		215-18-8401	5. Sex 7. 1 □ M 2 🏋 F	Age (In yrs. II	Yrs.	Months Days	Hours	Min.	Month, Day, July 28,	1912	9. Birth Cou St.	place (State or Foreign intry) Pau1, MN	7
	and *		10a. State 10b. County		10c. City	, Town or Lo	ocation	-					10d. Inside City Limits	-
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	1he 288	Jec.	10e. Street and Number	, , , , , , , , , , , , , , , , , , , ,		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10f, Zip Code			10	g. Citizen of V	What Cou	intry?	-
	3s or	<u></u>	4515 Willard Ave	., Apt. 90	04 S		20815				U.S.A	١.		
	death ma 2	Jera	11. Marital Status	12. Was Decede	ent Ever in U.S	S. 13.	Was Decedent of Hi	ispanic Orig	gin? (Spec	cify Yes or No-	14. Rac	e - Amer	ican Indian,	-
9	or ite		1 Never Married 2 Marrie	d 1 ☐ Yes 2		1			, Pueno F	tican, etc.)		k, White		
933	ours	d by	3 X Widowed 4 □ Divorced	Year or Date	es:		1 163 ZA 110	эрөспу.			Specify	/ Whi	.te	
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4515 Willard Ave., Apt. 904 S. Social Security Number of Disaster Company of the	or 5+)						IInholo	+ 0 25	Company					
		<u>v</u>	Company	-										
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<u></u>	shoul nd Me mari imati					19b. Mailie	ng Address (Street a					State, Zi	p Code)	_
Physician (Medical Examiner Marianthe S. Drac 4a. Facility Name (If not institution, give street and 4515 Willard Ave., Apt 4515 Willard Ave., Apt 15. Social Security Number 215-18-8401 15. Social Security Number 215-18-8401 15. Social Security Mountgomery 15. Social Security Number 215-18-8401 16. Sex 215-18-8401 17. Father Street and Number 4515 Willard Ave., Apt 11. Marital Status 15. Decedent's Education (Specify only highest grade comple 16. Sex 17. Father's Name (First, Middle, Last) 18. Informant's Name/Felationship (Type, Print, Theodora D. Argue/ Dau 20a. Method of Disposition 1 (Xigurial 2 Cremation 3 Removal from the Course of Print Specify) 21. Signature of Eineral Service Licensee 22a. Part 1. Enter the disease, or complications to shock or heart failure. List only one cause Immediate Cause (Final disease or conditions, from the past 12 months? 1 Yes 2Xino 23a. Part 1. Enter the disease, or complications to shock or heart failure. List only one cause Immediate Cause (Final disease or conditions, from the past 12 months? 1 Yes 2Xino 24. Department of the Course of Print Specify only highest grade conditions, from the past 12 months? 1 Yes 2Xino 25. Was case referred to medical examiner? 1 Yes 2Xino 26. Sex 27. Manner of Death 28a. Conditions 1 Yes 2Xino 29a. Certifier 29a. Certifier 1 Yes 2Xino 29b. Signature and title of certifier 29c. Ce	e/ Daughte	er	9370	Mercerwoo	od Dr.	., Me	rcer Is	land, N	WA980	040				
ē,	f Healitem			_	20b. PI	ace of Dispo	sition (Name of	(A)	Da	ate 2	0c. Location -	City or T	own, State	_
Ë	Page Int.	Director: Affer this certificate has been signed by the attending physician and some signed by the attending physician and some signed by the attending physician and some some signed by Physician/Medical Examiner To Be Completed by Physician/Medical Examiner							1/5/2	004 I	Rockvil	lle,	Maryland	
Balti	permit. Departnimporta		21. Signature of Funeral Service Li	censee	A10129	96 5	2. Name and Addres	ss of Facility Onsin	Jose Ave.	eph Gaw1	er's S ashing	ons, ton,	Inc. DC 20016	
	Pnysician	1 (8)	shock, or heart failure. List o Immediate Cause (Final	nly one cause on eac	h line.			g, such as o	cardiac or	respiratory arres	st,	J	Approximate Interval Between Onset and Death 2 Years	
鉄				Due to (or	as a consequ	ience of):							Years	_
	- 1983 	Je.	Sequentially list conditions, if any, leading to immediate										10010	-
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	ath certii ttending or use a	lan/Me	23b. Was decedent pregnant	1 Live birth	n 2 ☐ Fetal	death 3[23d. Dat	te of deliv	ery Day Year	
o	the de by the a ached f	Jysic	1 ☐ Yes 2 X No			eath 5L	Other (specify)							
	quires that n signed t uld be det	by	Part II. Other significant condition	s contributing to deat	h but not resu	ilting in the u	nderlying cause give	en in Part I.		•			the cause of death?	
Reco	he law rec e has bee age 2 shor	ompiete								autopsy	ed?	death?	opsy findings available empletion of cause of	
ta	an: T tificat tor, p		25. Was case referred to medical	SI				26 Place	of Death			I □ Yes	2□ No	_
<u> </u>	ysici is cer direc	0		Hospital: 1 ☐ Inp	atient 2 1	ER/Outpatier	nt 3 DOA Othe	00		5-3 %		er (Speci	fy)	
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Divis	al or Atte s after des tl Directo ed in by th	Sertific	datarmis	288. Place of	Injury - At ho etc. (Specify	me, farm, str	eet, factory, office		2			er or Rur	al Route Number,	
	n 24 hour ne Funera		(Check only 2 Medical E	xaminer: On the basi	s of examinat	wledge, deatlion and/or in	n occurred at the tim vestigation, in my op	ne, date and pinion, deat	d place, a h occurre	nd due to the cau d at the time, dat	ise(s) and ma e and place, a	inner as s and due t	stated. o the cause(s)	
	To the within To the comp	ž	29b. Signature and title of certifier)				290	d. Date signed	d (Month,	Day, Year)	
	17/		Dunn.	(-1/2	WILL	/	D394	456		Ja	anuary	5, 2	2004	
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									00,	Chevy Ch	ase, M	D 2	0815	_
					istrar's Signat	ure &	Sparks	2						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryla	na / Depa <i>Cer</i>	tificate of I	Death	nentai Hygi R•	ene _{g. No.} 2004	01524
	Dhysini	an a	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Helen Marie Drum					January	1, 2004	12:41 am
	Examin	er	4a. Facility Name (If not institution, give st				r Location of Death		4c. County of Deeth	
1			Suburban Hospita 5. Social Security Number 6. Sex		. last birthday)	Bethesd If Under 1 Year	a If Under 24 Hrs.	8 Date of Birth	Montgome	
	Funeral Director		198-01-3651	M 2DXF 8		Months Days	Hours Min.	8. Date of Birth (Month, Day, Nov. 5,	Year) Coul 1918 Pen	place (State or Foreign ntry) nsylvania
	land		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Mary a-f sh	tor	Maryland Montgome	ry B	ethesda					1 ☐ Yes 2 ☒ No
	or 284	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	ntry?
	ath w		5225 Pooks Hill Ro		th	2081			USA	
Q	be filed within 72 hours after death with the Maryland tal Hyglene d other then *natural', or items 23a or 28a-f show event. The Madical Examinal must be notified at	/ Funerai	1 ☐ Never Married 2 ☐ Married	 Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 		Vas Decedent of H FYes, specify Cuba I□Yes 2⊠No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.
	atural',	ted by	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	16a Daced	lent's Heual Occurs	ation	1	6b. Kind of Business/In	
Maryland 21215-0036	rithin 72 ne. hen "nu	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done of OO NOT use retired	during most of work		D 3	
7	filed v Hygie other t		17. Father's Name (First, Middle, Last)		Secr	etary	18 Mother's Nam	e (First, Middle, M	Electronic	Company
<u>a</u>	should be nd Mental I marked o	To Be	Michael Patrick R	eidv				enevieve		
aZ	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Street a			City or Town, State, Zip	Code)
	and 2 ealth a n 27 i		Cynthia Finelli/		7000	West Gree			vy Chase, N	
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any Injury or other treumatic engine.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State 20b.	cemetery, cren rlingto	sition (Name of natory or other plac n Nationa emetery	Janua	ary 20	oc. Location - City or To	
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service License	•	22 F 1	Name and Address	ss of Facility Collins	Funeral	Home Inc.	
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the dea	50 ath. Do not ente	00 Univer	sity Blvc	1. W., Si	lver Sprin	g, MD 20901 Approximate
	Pnysician		shock, or heart failure. List only one Immediate Cause (Final disease or condition	e cause on each line.	,J	CANO			11	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):	U-1/	-6/			1 4700
		e	Sequentially list conditions, b.	Due to (or as a sonse	quenes of):					
	cuted nd ransit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.							
60,	ificate be executed g physician and as the buriat-transit		resulting in death) Last	Due to (or as a conse	quence of):					
68760	phy:	edical	d.							
O. Box	e death certif the attending hed for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	dc. If yes, outcome of preging to Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
عذ	res that the de igned by the a be detached f		Part II. Other significant conditions cont	ributing to death but not re	sulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to the	ne cause of death?
rds	w requires that the been signed by th should be detache	ed by						1 ☐ Yes	2 XWo 3 □ Prot	pably 4 Unknown
Vital Records,	e law has b	Completed						24a. Was an autopsy perform	prior to co	psy findings available mpletion of cause of
ā	ician: Th certificate rector, pag		25. Was case referred to medical				26 Place of Deat	1 Yes 2	No 1 ☐ Yes	2□ No
	Physician: ' this certifica	To Be	examiner?	ospital: 1 patient 2	☐ ER/Outpatien	t 3 DOA Othe	0.0	-11	ce 6 □Other (Specif	v)
on o	ling After fune		27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	y at	28d. Describe how		
Division of	- 9 -	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre hojfy)			28f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
	To the Hospital of within 24 hours aft of the Funeral Discompletely filled in	Medical C	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examin	ician: To the best of my kr er: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at the time restigation, in my op	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	use(s) and manner as s e and place, and due to	tated. the cause(s)
	Fo the within Fo the	Me	29b. Signature and title of certifier	-/J		29c. License			d. Date signed (Month,	
-	. 1		1 Kilmo &	Vide	4.5	> De	0957	7 1	11104	
	10		30. Name and address of person who cor	mpleted cause of death (Ite	em 2.a) (Type,	Print) 101	100 (0)	ope ct	CONT AVO	tt 606
			RICCHARD H.	Porces	لبر	Dice	PSIACI	170	1104 CONT AUG MED 21	895
	Sta Registi		JAN 0 6 2004	32. Registrar's Sign	nature &	book	/	,		

Drumm, Helen M.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3, January 2004 5:05 PM Doris S. Dutch /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Prince Georges Upper Marlboro 9716 Lemocks Drive | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Yeer) | Nov. 4, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 💢 F 59 Yrs. 1944 Wash. D.C. 577-58-8506 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No Director MD. Prince Georges Upper Marlboro 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 20772 9716 Lemocks Drive United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: ð 3 ☐ Widowed 4 ☑ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Program Specialist Metro 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gloria Winifred Edge William Louis Dutch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wendell Anthony Person / Son 5002 Lee Jay Drive, Capitol Heights, MD. 20743 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Harmony Memorial Park 1 D Burial 2 □ Cremation 3 □ Removal from State 1/9/04 4 ☐ Donation 5 ☐ Other (Specify) Landover, MD. 22. Name and Address of Facility McGuire Funeral Service 21. Signature of Funeral Service Licenses 7400 Georgia Ave., N.W. Wash. D.C. uhan romasi 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Aviedical. Immediate Cause (Final disease or condition resulting in death) Metastatic Breast Cancer Examiner Due to (or as a consequence of) Physician/Medical Examiner attending physician end for use as the buriel-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) resulting in death) Last 23b. DId tobacco use contribute to the cause of death? certificate hes been signed by the a rector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown ò 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 2 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation М 1 Tes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1X Certifying Physician: To the best of my knowledge, death oncurred at the time, date and piece, and due to the cause(s) and manner as stated 29a Cartflet edicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of contifig 29c. License number 29d. Date signed (Month, Day, Year) D20352 January 8, 2004 5 of death (Item 23a) (Type, Print) 30. Name and address of person no como eted c 7525 Greenway Center Dr., Greenbelt, MD. M.D. Harvey I. Katzen,

32. Remistrar's Signature

Looks

State Registrar 31. Date filed (Month, Day, Year)

JAN 09

2004

			For State Registrar	State of I	Maryland / Dep <i>Ce</i>	artment of H			ene 200	4 01526
			Decedent's Neme (First, Middle, Las	t)				2. Date of Death	1	3. Time of Death
	Physici /Medio		Joseph F. Elmo					Month January	4, 2004	2:30P ^M
)	Examir		4e. Fecility Name (If not institution, give	street and number	er)	4b. City, Town, or	Location of Death		4c. County of De	
			Montgomery Gener	al Hospi	tal	01ne	y		Montgon	nerv
	Funeral		5. Social Security Number 6. Se	7.	Age (In yrs. last birthday		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		irthpleca (State or Foreign Country)
	Director		577-09-1289	X M 2□F	94 ^{Yrs.}	Widiniis Cays	THOUSE INITIA	May 19,		shington, DC
	p a		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or L					1.0.1.1.1.1.0.1.1.1.1.1.1.1.1.1.1.1.1.1
	anyla sho	<u>></u>								10d. Inside City Limits 1 ☐ Yes 2 No
	Ba-f	Director	Maryland Montgo	mery	Silver					
	with t	ă	10e. Street and Number			10f, Zip Code		10	g. Citizen of What (Country?
	s 23	Funeral	13204 Glenhill R			20904			UŞA	
	er de Item	une	11. Marital Status	12. Was Decede Armed Force	s?	Was Decedent of Hi tf Yes, specify Cuba	spanic Origin? (Sr n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh	
36	s aft	Ϋ́F	1 ☐ Never Married 2 1 Married 3 ☐ Widowed 4 ☐ Divorced	1 Tes 2 (If Yes, Give Year or Date	Δ.	1 ☐ Yes 2 🕏 No	Specify:		Specify:	
21215-0036	72 hours after death with the Maryland hetural', or items 23s or 28s-f show dical Examiner must be notified at	Completed by	15. Decedent's Ed			dent's Usual Occupa	ation		Oh Kind of Business	White
5	in 72	Set	(Specify only highest grad	de completed)	(Give	kind of work done of DO NOT use retired	luring most of worl)	ting '	6b. Kind of Busines	sandustry
12	with iene.	E	Elementary/Secondary (0-12)	College (1-4d	or 5+)	perintend			Construc	tion
	Hyg Hyg other	Be C	17. Father's Name (First, Middle, Last)			portmond		e (First, Middle, M		CIOII
Maryland	ld be ental ked c sv	To B	Angelo Francis E	1mo			Catha	rine Joan	Dromos	
7	shound M mar mar	-	19a. Informant's Name/Relationship (T		19b. Maili	ng Address (Street a				Zin Code)
Ž	th a 27 is r trau		Katherine E. Fle	tcher/Da		3 St. And				
Ē,	Hea Hea Item		20a. Method of Disposition		20b. Place of Dispi	osition (Name of			Oc. Location - City o	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Importent: If item 27 is marked other than "netural", or items 23a or 28a-f show eny injury or other traumatic event, the Madical Examinar must be notified at once.		1 Burial 2 Cremation 3 1		10	matory or other place			04 Balti	
	artme orten injur		21. Sign ture of Foneral Service Licens			Park Crema 2. Name and Addres		The second secon		
B	Depa Impo eny ir		Proto	Del	//					ng, MD 20904
	V.		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only of	lications that caus	ed the death. Do not en line.	er the mode of dying	, such as cardiac	or respiratory arres	st,	Approximate Interval Between
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d	/Medical		resulting in death)	a	as a consequence of):					700
	Examiner		Sequentially list conditions,	b						
	D #	Examiner	cause. Enter Underlying	Due to (or o	s a consequence of):					
	acute ind trans	am	Cause (Disease or injury that initiated events	с.						
ŠÓ,	rcate be executed physician and s the burial-transit	Œ.	resulting in death) Last	Due to (or a	as a consequence of):					
8760,	ate b hysic the b	dical		d						
9	eath certific attending p	4	IF FEMALE:							
Box	ath ce	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	ne of pregnancy 2 Fetel death 3	Ectopic pregnancy			23d. Date of de	
	e dea	200	1 ☐ Yes 2 ☐ No	4□Pregnant 9□ Unknown	at time of death 5	Other (specify)			Month	Day Year
0.0	that the de led by the a detached f	Phy	9 Unknown							
Ś	Se D 90	ρ	Part II. Other significant conditions co	ntributing to death	but not resulting in the u	nderlying cause give	n in Part I.		\ /	o the cause of death?
Records,	w equin	Completed	Tunan	1 your	- There		- (1//)	1 🗌 Yes	2 2 00 3□P	robably 4 DUnknown
ec	has be	be	Insulus (Depend	lento Dr	abetes	Mellit	44a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
		Ö		1				performe	death?	2 No
Vital	yalcien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?				26. Place of Deatl	(Check only one)		
	\$ 5 D	2	1 Yes 2 No	Hospital.	tient 2 ER/Outpatier	t 3 DOA Dthe	4 Nursing Ho	me 5 🗆 Residen	ce 6 Other (Spe	cify)
Division of	ng Ph ter th neral		27. Manner of eath Natural 5 Pending	28a. Date of Ir (Month, L		28c. Injury Work		28d. Describe how		
0	endii sath. or: A he fu	ati	2 ☐ Accident investigation				es 2 No			
ž	al or Attending P after death. I Director: After t d in by the funera	≝∣	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of I	njury - At home, farm, str etc. (Specify)	eet, factory, offica		28f. Location (Stre City or Town,	et and Number or R	ural Route Number,
	ital or rs aff	Certification:						,,	2.2.0)	
	dosb t hon uner	cal	29a. Certifier Certifying Phy	sician: To the bes	st of my knowledge, death of examination and/or in	occurred at the time	e, date and place,	and due to the cau	se(s) and manner as	s stated.
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Medical	une)	and manner	stated.					
	To To com	2	29b. Signature and title of certifier	3	×1. 0	29c. License	number	290	. Date signed (Mont	h, Dey, Year)
	12		VVIKKINS	m J	· Ninale	Y DL	42 X8	2 3	muany	4,2004
	10		30. Name and address of person who co	ompleted cause of	death (Item 23a) (Type,	Print RP	#112 (Pales ST	rina MI	20021
			WJ Winder	, 344	f Umvers	Jana.	11 (10)	10000	J, rea	20 10)
	Sta Registra		31. Date filed (Month, Day, Yeer)		strar's Signature	Sporks	/			

			partment of Health and Nertificate of Death	Reg. N		01527
Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last) Carol Ann Ellis 4a. Facility Name (If not institution, give street and number) Holy Cross Hospital	4b. City, Town, or Location of Death Silver Spring	January 2	2004 c. County of Death	3. Time of Death 7:38 A M
Funeral Director		5. Social Security Number 216-40-8743 Cusual Residence of Decedent 6. Sex 1 □ M 2 ⋈ F 7. Age (In yrs. last birthda 1 □ Yrs.		8. Date of Birth (Month, Day, Year Oct. 12, 19	r) 9. Birtholi Count	**
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.	To Be Completed by Funeral Director	1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Spring 10f. Zip Code 20901 3. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 1 Tyes 2 No Specify: Dedent's Usual Occupation we kind of work done during most of work DO NOT use retired) If ied Dental Assist 18. Mother's Nam Verna Verna illing Address (Street and Number or Rur Position (Name of Paramatory or other place) Heaven Cemetery Jan. 6 22. Name and Address of Facility Trancis J. Collins 500 University Blvd	ecity Yes or No-Rican, etc.) ing 16b. ant De e (First, Middle, Maide Muha al Route Number, City Iver Sprin Date 5,2004 Silve Funeral Ho ., W., Silve	USA 14. Race - America Black, White, e Specify: Wh: Kind of Business/Ind ental en Sumame) or Town, State, Zip cor Town, State, Zip cor Spring me, Inc. r Spring,	in Indian, otc. ite ustry Code) 20901 wn, State , Maryland
death certificate be executed death certificate be executed death certificate be executed e attending physician and dor use as the burial-transit	edical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not deshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially fet condition of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Lirreversable Bower Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	el Obstruction		18	Approximate Interval Between Onset and Death Smonths Vears
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det bat	Completed by Phy	Part II. Other significant conditions contributing to death but not resulting in the Pneumonia			death?	
or Attending Physician: Itler death. Director: After this certifice in by the funeral director,	Certification; To Be C	25. Was case referred to medical examiner? 1 Yes 2 No 1 Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year) 28b. Place of Injury - At home, farm, building, etc. (Specify)	of 28c. Injury at Work? M 1 Yes 2 No	h (Check only one) ome 5 Residence 28d. Describe how inj 28f. Location (Street a City or Town, Sta	6 □Other (Specify, ury occurred	
To the Hospital or within 24 hours after To the Funeral Director completely filled in I	Medical Ce	29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowledge, de (Check only one) 1 Madical Examinar: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	red at the time, date ar	s) and manner as sta nd place, and due to late signed (Month, D	the cause(s)
10		30. Name and address of person who completed cause of death (Item 23a) (Type	D02338	Janı	uary 2. 20	
S1 Regis	tate	Richard P. Delaney, M.D. 3929 Ferra 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ra Drive Wheaton,	Maryland	20906	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Bessie ELFIN 8 2004 1:20 P January /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hebrew Home of Greater Washington Rockville
If Under 1 Year | If Under 24 Hrs. Montgomery Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 ☐ M 2 🎖 F 95 Director 133-09-2545 July 30, 1908 New York Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Item 27 is marked other than "neturel", or Items 23s or 28s-f show other traumatic event, the Middical Execution must be notified at 1 ☐ Yes 2 ☑ No Rockville Maryland Montgomery Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 20852 United States 6105 Montrose Road #2205 South Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 247 No If Yes, Give^X Year or Dates; 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Minnie Barr Joseph Margolis ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 4515 - 30th St., NW, Washington, DC Mel Elfin, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3X Removal from State * 4 Donation 5 Dother (Specify) United Hebrew Cemetery 01/11/04 Staten Island, NY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home, Inc. 254 Carroll St., NW, Washington, DC 20012 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Bowel obstruction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Incarierated Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed iis certificate has been signed by the attending physicien and director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Medical Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Honknown cordierasinka 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 24 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deatl 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 022520 mID. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20852 RUCKUICLE MARGLAND 6121 3. Wilks, MONTROIG Gary 31. Date filed (Month, Day, Year) 32. Registrar's Signature State souks JAN 09 2004 Registrar

			1 - For State Registrar	State	of Marylar	nd / Depa	artmen rtificat	t of Health e of Death	and M		giene Reg. No.		01:	529
	Physici	an	Decedent's Name (First, Middle					_		2. Date of Dea Month	Day	Yeer	3. Time of	
	/Media		Clarence	Α.		Emrick	4 0	Sr.		JANUAR?	_	2004		P M
	Examir	ner	4a. Fecility Name (If not institution MEMORIAL HOSPI		imoer)			Town, or Location IBERLAND	or Death			County of Dea		
-	uneral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year If Under		8. Date of Birth	h	9. Bir	hplece (State o	or Foreign
	irector		213-22-3945	1 □XM 2 □ F	77	Yrs.	Months	Days Hours	Min.	Month, Day Mar 2	6, 1	926	PA	
pur	3		Usual Residence of Decedent 10a. State 10b. County		10c Ci	ty, Town or Lo	cation						10d. Inside C	ity Limits
Manyla	faho	٥		gany	10010		berlar	nd					1 🔀 Yes	
the	r 28a-	rect	10e. Street and Number				10f. Zip	Code			10g. Citi	zen of What Co	ountry?	
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r deal	E III	ner	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13.	Was Deced	lent of Hispanic Or ofy Cuban, Mexical	igin? (Spe	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit		
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B hour	al E2	ed t	15. Decedent	Year or (Dates: VVV	1	dent's Usua	Il Occupation			16b. Ki	nd of Business		
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2 E	o d o d o	Be	17. Father's Name (First, Middle, I							(First, Middle,				
should	is marked other the	ပ				10h Mailie	na Addraga			M. (Smit			Tin Code)	
	27 is r		19a. Informant's Name/Relationsh Brian Emrick	S	on	131	15 Ac	(Street and Number re Lane	er or nora	Cumb	erla	nd	MD 21	502
ב – ע	Iten other		20a. Method of Disposition			Place of Dispo cemetery, crer	sition (Nan	ne of	0	ate	20c. Lo	cation - City or	Town, State	
Pages	iry or	,	1 ☐Burial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other (Sp		State Hil	Icrest Me	morial	Park		1/21/2004	Cu	mberlar	nd	MD
permit.	Department or result and when a region of the second secon		21. Signature of Funeral Service I	_icensee		, 22	. Namean	arpelli Fune	al Ho	ome. PA				
u & c	2 2 2 9		James	D+ C	end	MI	10	8 Virginia A	venue	· Cumber		MD 2150		
			23a. Part1. Eiler the disease, or shock, a heart failure. List	complications that only one cause on	caus of the dea each line.	th. Do not ent	er the mod	e of dying, such as	cardiac o	r respiratory ari	est,		Approximat Interval Bet Onset and I	e ween Death
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	aminer				(or as a consec		ur nu	TACATADA	D.T.O.D.A	a.e.				D.G.
A Company	1000	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(or as a consec		VE PU	LMONARY I	DISEA	SE			5 YEA	RS
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be executed	ian ar urial-t		resulting in death) Last	Due to	(or as a consec	quence of):								
cate b	physician and s the burial-transit	dica		d										
The law requires that the death certificate	D &	Physician/Medical	IF FEMALE:	23c. If ves. ou	itcome of pregn	ancv						12d Date of dal		
leath C	atten I for u	clan	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 ☐ Feta nant at time of c	aldeath 3[Ectopic pro				4	3d. Date of del Month	-	Year
j	by the achec	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkr	nown			,,						
s tha	igned by the attendir be detached for use	by P	Part II. Other significant condition	ns contributing to	leath but not res	sulting in the u	nderlying ca	ause given in Part I		23e. Did to	bacco u	se contribute to	the cause of d	eath?
equire 5	been sig									1 Ø Y	es 2[□No 3□Pr	obabiy 4 🔲 l	Inknown
N ×	SC	Completed								24a. Was a		24b. Were au	topsy findings : completion of ca	available ause of
	s certificate has b lirector, page 2 s	Con								perfor	med? 2 2 No	death?	2 🗆 No	
VICIAN	certifi	Be	25. Was case referred to medical examiner?	Hospital:				04		(Check only or				
or Attending Physician:	a this	To :	1 ☐ Yes 2 ☐ No 27. Marper of Death	28a. Date	of Injury	28b. Time of		A 4 Nu Bc. Injury at Work?		ne 5 Reside			cify)	
g ding 4	: Alter e funer	tior	1 Natural 5 Pending 2 Accident investig) (Mor	nth, Day Year)	Injury	М	Work? 1 ☐ Yes 2 ☐						
Atte	rector: by the	ertification;	3 Suicide 6 Could n	ned 286. Place	e of Injury - At h	ome, farm, str	eet, factory	, office	2	28f. Location (S. City or Town			ral Route Num	ber,
	ed in	O	4	Dunc	intg, etc. [Opeci	· y /				Only of Town	i, State)		•	
the Hospital	To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical I	g Physician: To the background	pasis of examina	owledge, death	occurred a	at the time, date an	nd place, a	and due to the c	ause(s) ate and	and manner as	stated. to the cause(s)
o the	the mplet	Med	29b. Signature and title of ceptrier	and mar	ner stated.			License number				signed (Mont)		
2	- 3		10,5	10/1200	10 h.	h		016041						
			30. Name and address of gerson	who completed cau	se of death (Iter	m 23a) (Type.		710041			JAN	UARY 19	, 2004	
			TERRY WILLIAMS,	M.D. 50	O MEMOR	IAL AVE	ENUE	CUMBERLA	ND,MI	D 21502				
美	Sta		31. Date filed (Month, Day, Year)	32.	Registrar's Signa	ature	a. N. i	,						
	Registr	ar	IAN 2 2	ZUU4 /	PARILES .	As As	ALC: NO.							

Physici /Medi

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, it a Madical Examination and the contract of the contract of the Madical Examination of the contract of the

carel Ann Ferriero

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

For State Registrar	State of Ma	ryland / Dep	ertificate of		ınd Mental H	Hygiene 2	004	0153
Decedent's Name (First, Middle, Last)			Timodio o.		2. Date of			3. Time of Death
	RRIERO				Month	ary 7	2004	0855 AN
4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, o	r Location o	f Death	4c. Co	unty of Death	
Memoriai Has	spital AT	Faston	Easto			Ta	ibot	
5. Social Security Number 6. Sex		(In yrs. last birthday) If Under 1 Year		24 Hrs. 8. Date of	Birth	9. Birth	place (State or Foreig
142-34-4256 ^{1□}	M 213 F	61 Yrs.	Months Days	Hours	Min. 04/2	Day, Year)	Mar	yland
Usual Residence of Decedent		01	-l		04/2	2/ 4/3	1101	Jiana
10a. State 10b. County		10c. City, Town or I	ocation					10d. Inside City Limits
MD Carolin	ne	Prest	on					1 ☐ Yes 2 ∏ No
						1		
10e. Street and Number			10f. Zip Code				of What Cou	-
22084 Havercam	o Road		216	55		Unit	ed St	ates
11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13	. Was Decedent of I	lispanic Orig	in? (Specify Yes or		Race - Ameri	
1 Never Married 2 Married	1 ☐ Yes 2X No	0			, Puerto Rican, etc.)		Black, White	
3 ₩idowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Sp	ecify: W II	ite
15. Decedent's Educ	cation	16a Dec	edent's Usual Occup	nation		16h Kind (of Business/Ir	ndustry
(Specify only highest grade		(Giv	e kind of work done DO NOT use retire	during most	of working	Tob. Tallo	7 DUSHIOSSII	1000(1)
Elementary/Secondary (0-12)	College (1-4or 5+	-)	sociate	υ)		Wal:	mart	
		ASS	ociale.					
17. Father's Name (First, Middle, Last)					r's Name (First, Mid			
Samuel Frant				l .	Patric			
19a. Informant's Name/Relationship (Ty) Jean Ferriero/I			ling Address <i>(Street</i> 391 Carr					
Jean Ferriero/1				туп г				
20a. Method of Disposition		20b. Place of Disp cemetery, cri	position (Name of ematory or other pla	ce)	Date	20c. Locati	on - City or T	own, State
fi☐Burial 2 ☐ Cremation 3 ☐ R * 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		y Cemet		/10/04	Fede	ralsb	urg, MD
21. Signature of Funeral Service License	96	1	22. Name and Addre					
Mariation	m (1200			TIGHTOL	om rune	eral .	Home, PA
23a. Part1. Enter the disease, or compli) ///. Ca	ace					ourg,	MD 2163
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	2 ☐ Fetal death 3	□Ectopic pregnanc	y		23d.	Date of deliv Month	ery Day Year
Part II. Dther significant conditions con	tributing to death but	t not resulting in the	underlying cause giv	ren in Part I.	23e. D	id tobacco use	ontribute to t	he cause of death?
Gram positive	Stos	15			1	☐Yes 2XN	o 3 🗆 Prol	ably 4 Unknow
	, -				24- 14			
						utopsy	prior to co	opsy findings available impletion of cause of
					1 ☐ Ye	erformed? es 2 X No	death? 1 ☐ Yes	2 🗆 No
25. Was case referred to medical				26. Place	of Death (Check on			
examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 XInpatien	nt 2 ER/Outpatio	ent 3 DOA Oth	no.	rsing Home 5 🗆 A		Other (Sneci	(v)
27. Manner of Death	28a. Date of Injury (Month, Day			y at		be how injury oc		<i>y</i> /
1 Anatural 5 ☐ Pending 2 ☐ Accident investigation				Yes 2 1	10			
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur	ry - At home, farm, s	treet, factory, office		28f. Locatio	n (Street and Ni Town, State)	ımber or Rur	al Route Number,
	Danishing, Otto.	(200.17)			0.1.9 07	. J, G(a)6/		
	1	f my knowledge, dea	ath occurred at the til	me, date and	d place, and due to the firm	the cause(s) and	manner as s	stated.
(Check only 2 Medical Examin	sician: To the best of ner: On the basis of o	examination and/or i						,-,
(Check only 2 Medical Examination)	sician: To the best of ner: On the basis of and manner stat	examination and/or i led.	000 1:	o number		204.5		Day V
(Check only 2 Medical Examin	ner: On the basis of a	examination and/or i	29c. Licens			29d. Date sig	gned (Month,	Day, Year)
(Check only 2 Medical Examination)	ner: On the basis of a	examination and/or i		e number		29d. Date sig	gned (Month,	Day, Year)
(Check only 2 Medical Examination)	ner: On the basis of and manner stat	ed.	14-		,	29d. Date sig	gned (Month,	Day, Year)
2 Medical Examirations) 2 Medical Examirations) 29b. Signature and title of certifier 30. Name and address of person who co	and manner stat	ath (Item 23a) (Type) 4-	1232		1/0	7/2	Day, Year)
(Check only 2 Medical Examirone) 29b. Signature and title of certifier	mer: On the basis of and manner stat	ath (Item 23a) (Type	o, Print)	1232		29d. Date sign 1	7/2	Day, Year)
(Check only 2 Medical Examirone) 29b. Signature and title of certifier	ner: On the basis of and manner stat	ed.	14-			29d. Date sig	gned (Month,	Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Regist

State of Maryland / Department of Health and Mental Hygiene 004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Physician HERBERT C. FERRAND 012004 4:30 AM JAN /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Salisbury Rehab and Nursing Center
5. Social Security Number | 6. Sex | 7. Age (In yrs. last bird Wicomico Salisbury, Md. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 02-07-1913 Birthplace (State or Foreign Country)
 NEW YORK 7. Age (In yrs. last birthday) **Funeral** Deys Months 1∭ M 2□ F Yrs. 116-07-0694 90 Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "naturel", or Items 23s or 28s-f show any Injury or other traumatic event, the Medical Evantinar must be notified at once. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MD WICOMICO SALISBURY Funeral Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1401 GLEN AVENUE 21804 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE ģ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 4 ACCOUNTANT PRIVATE 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CLARENCE FERRAND ELSIE KIEFER 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) HELEN FERRAND - SPOUSE 401 GLEN AVENUE, SALISBURY, MARYLAND 21804 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) CREMATORY OF DELMARVA 01-03-04 DELMAR, DELAWARE 22. Name and Address of Facility
BOUNDS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, last only one cause on each line. shock, or heart failure. Approximate Interval Between Physician /Medical Immediate Cause (Final disease or condition resulting in death) 10 days cerebrovascular Examiner Due to (or es e consequence of) Physician/Medical Examiner or Attanding Physician: The law requires that the death certificate be executed attending physician and I for use es the buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of) Division of Vital Records. P.O. Box 68760. Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed by To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tes 21 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: Certification: To 1 Yes 2 No 3□ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 ☐ Homicide within 24 hours a To the Funerel D Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier (Check only one) and manner steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 030853 04 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) B. S. Ivia Jrum 1346, S. Division St. Suite, Salisbury, Md. 21804 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State Sporks

DHMH 16 Rev 6/95

Registrar

HERBERT C. FERRAND

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			Please Type or Print State of Mai					_	_	·		
			State	ylanu		tificate of l			200	4 01532		
1			Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death		
	Physici /Medio		NIKKI RAE FLEMETAKIS				J	anuary	6 2004	3:00 A M		
	Examir		4a. Facility Name (If not institution, give street and number)				Location of Death		4c. County of D			
			Southern Maryland Hospital (5. Social Security Number 6. Sex 7. Age	Centei (In yrs. lasi		Clinto	If Under 24 Hrs.	8. Date of Birth	Prince G			
	Funeral Director		104 205	49	Yrs.	Months Days	Hours Min.	UG 31 1	954 Ca	Birthplace (State or Foreign Country) alifornia		
2	/land		10a. State 10b. County		Town or Lo	cation				10d. Inside City Limits		
dr	a-f sh	Director	Maryland Charles	Wald	orf					1 X Yes 2 □ No		
m	or 28	Dire	10e. Street and Number			10f. Zip Code	3	10	og. Citizen of What USA	Country?		
	sath w	eral	9360 Frances Street 11 Marital Status 12. Was Decedent Ev	ver in IJS	13 V	2060		cify Yes or No-		merican Indian,		
1-6.04	be filed within 72 hours after death with the Maryland tal Hygiene. Ided Hygiene. Ided other than "natural", or terms 23a or 28a-f show event, if a Medical Examiliar Institute and the motified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 【★Divorced 12. Was Decedent Express? 1 □ Yes 2 ★ No. If Yes, Give Year or Dates:			Yes, specify Cuba	ispanic Origin? (Specin, Mexican, Puerto F Specify:	Rican, etc.)	Black, W	thite, etc. White		
6.09	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	1	(Give	lent's Usual Occup	during most of working	g	16b. Kind of Busine	ss/Industry		
3 5	within one.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ا ۱۱۴۵. House	NOT use retired wife	1)		Own Home			
	Hygie ant.	Be Co	17. Father's Name (First, Middle, Last)		TOUDC		18. Mother's Name					
2	uld be Mental rked of	To B	Nicholas Flemetakis				Ida O'Bri	en Flem	etakis			
expired Maryland	od 2 shouth and A th and A trauma	1 100	19a. Informant's Name/Relationship (Type, Print) April L. Oswald (Daughter)				and Number or Rural Fish Place					
2 9	s 1 an t Heal tfem 2		20a. Method of Disposition	20b. Plac	e of Dispos	sition (Name of natory or other place	Da		20c. Location - City			
J. C.	Page Page Int: If	Ш	1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State • 4 ☐ Donation 5 ☐ Other (Specify)	Metr	opoli	tan Crema	atory 1-7-	-04 A	lexandri	a, VA		
3	permit. Pages 1 and 2 should be filed within 72 bearmit of Health and Mental Hygiene. Important: If Item 27 is marked other than "nn any injury or other traumatic event, trankfull once.		21. Signature of Pymeral Service Licensee	м 001	13	. Name and Addres	ss of Facility Ebe e Pls. La.		uneral So Pls., MD			
			23a Part 1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line	he death. 3.	Do not ente	er the mode of dyin	g, such as cardiac or	respiratory arre	st,	Approximate Interval Between Onset and Death		
	Physician			XAN'S						Oriset and Death		
	/Medical Examiner		resulting in death) Due to (or as a	consequer	nce of):							
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V 687	h certific ending p	/Mec	IF FEMALE: 23c. If yes, outcome or	of pregnanc	v				23d. Date of	delivery		
TX CT	the att	Physician/Medic	23b. Was decedent pregnant in the past 12 mg/mths? 1 □ Vres 2 □ No 9 □ Unknown	2 Fetel de	eath 3	Ectopic pregnancy Other (specify)			Month	Day Year		
1 / 1	ires that the signed by dise detac	by	Part II. Other significant conditions contributing to death but	tions contributing to death but not resulting in the underlying cause given in						co use contribute to the cause of death?		
emetakes NI	w requir been si should	Completed						24a. Was ar		autopsy findings available		
	The lav	шо						autops perform	ned2 death	to completion of cause of		
2 1	ysician: The lis certificate hadirector, page	O	25. Was case referred to medical			1,725	26. Place of Death					
V:	Physici Physici this ce	To B	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
To	ding Pl	on:	27. Manny of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Work? North of Death 28d. Describe how injury occurred Work? M 1 Yes 2 No									
0 3	or Attending Physician: titer death. Director: After this certification by the funeral director.	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injur	ry - At hom	e farm stre			8f. Location (Str	reet and Number or	Rural Route Number,		
eme ta	l or Attendate death Director:	Certification:	4 Homicide determined building, etc.	(Specify)	o, 141111, 3111	sot, ractory, critico]	City or Town				
I	To the Hospital or within 24 hours at To the Funeral D completely tilled in	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of and manner state and manner state.	examination	edge, death n and/or inv	occurred at the time vestigation, in my o	ne, date and place, a pinion, death occurre	nd due to the ca	use(s) and manner ite and place, and o	as stated. due to the cause(s)		
	To the within 2 To the comple	Me	29b. Signature and tille of certifler			29c. Licens	e number	29	d. Date signed (Mo	onth, Day, Year)		
			▶ Klalinin MD			2005	15 120		Jan 6 20	04		
	P		30. Name and address of person who completed cause of de- lighted (culpus MD 1326 fee	ath (Item 2)	3a) (Type, Aves	Print) rue SE Se	uk 310 b	Vashing,	bade 20	032		
		ate	31. Date filed (Month, Day, Year) 32. Registrar	r's Signatur								
	Regist	rar	JAN 0 8 2004 Lieux	us s	B. 16	parle						

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expired 1-6:04

Physici	an_	1. Decedent's Name (First, Middle, L	ast)	,	,					2. Date of De Month JAN •	Day	OO4 Year	3. Time of 0851	Death A M		
/Medic Examir	al	Kelth Robert Fetriage 4h City Town or location of Death										2 , 2004 0851 4c. County of Death MONTGOMERY				
uneral irector	*	5. Social Security Number 6. 028–46–0401	(In yrs. la	ist birthday) Yrs.	If Under Months		If Under Hours	Min.	8. Date of Bi (Month, Di Nov. 1	rth ay, Year)	Co	hplace (State of	Foreign			
	_	Usuel Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation				-			10d. Inside Ci	-		
or 28a-f	lrecto	Maryland Montgor 10e. Street and Number	nery	Pot	omac	10f. Zip	Code				10g. Citiz	zen of What Co				
Department of Health and Mental Hygiene. Importent: or items 23a or 28a-f ehow Importent: If item 27 is marked other than "natural", or items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	12908 Three Sist 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	20854 (ver in U.S. 13. Was Decedent of Hispanic Origin? (Specit Yes, specify Cuban, Mexican, Puerto R						United States acify Yes or No- Rican, etc.) 14. Race - American Inc Black, White, etc. Specify: White							
	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	rade completed) College (1-4or 5	College (1-4or 5+)			rk done d se retired	during mos 1)				nd of Business/Industry				
	To Be Co	, , , , , , , , , , , , , , , , , , , ,							er's Name	countant Accounting Name (First, Middle, Maiden Sumame) nia Rute						
aumati	ř	19a. Informant's Name/Relationship	(Type, Print)			-		and Numbe	er or Rura	Route Numb		r Town, State, 2				
or other tr		Ellen K. Fetridg 20a. Method of Disposition 1 Burial 2 Meromation - 3	☐Removal from State	Ce	ace of Dispe	osition (Nar	ne of	(a)	D.	ad, Po	20c. Lo Germ	cation · City or antown, M	Town, State Yaryland	ы		
Importent: any injury once.		1 Surial 2 Screenism 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Survice Licensee 22. Name and Address of Facility Rockville, Inc. 30 West Montgomery Avenue MO0803 Rockville, Maryland 20850-2805														
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within 24 hours after death. To the Funerel Director: After this certific compietely filled in by the funeral director.	Medical Certification;	1 Natural 2 Accident 3 Suicide 4 Homicide 1 Natural 2 Replace of Injury - At home, farm, street, factory, office building, etc. (Specify)							28d. Describe how injury occurred INHALED EXHAUST FUNES 28f. Location (Street and Number or Rural Rou City or Town, State)				ber. WI			
lled i	ical Cel	29a. Certifier (Check only 29a Certifier (Ch														
ely f		29b. Signature and title of certifier O.C.M.E								29d. Date signed (Month, Day, Year JAN . 3, 2004						

			1 - For State Registrar	State of N		d / Depa		t of H	ealth a	and M	R	eg. No.	Z 11 11 11	and the second	015	34	
	Physici	an	1. Decedent's Name (First, Middle, Last								2. Date of Deat Month	Day	200Ye	er	3. Time of		
5	/Medic	al		idell	(c)		4h City	Town or	Location	of Death	January		3, 2004 10:45 A M				
	Examin	ner	4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Chevy Chase									1	Montgomery				
7	Funeral Director		5. Social Security Number 6. Se 577-16-1692	last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. NoV • 17,						9. Birthplace (State or Foreign Country) 1919 Washington, DC						
	and ow		Usuel Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							100	d. Inside Cit	y Limits	
	Mary First	ţ	Maryland Montgo	mery		Chev	y Cha	ise							1 🗌 Yes	2 X) No	
	d within 72 hours after death with the Maryland jiene. r than "natural", or items 23e or 28e-f show the Medical Ezaminer mutt be notified at	al Director	10e. Street and Number 10f. Zip Code 10g. 0 4601 North Park Ave., 915 20815								-	Citizen of What Country? U.S.A.					
	ems 3	Funeral	11. Marital Status 12. Was Decedent Armed Forces?			.S. 13.	Was Deced	dent of Hi	spanic Orig	gin? (Spec	cify Yes or No- Rican, etc.)	1	14. Race - American Indian, Black, White, etc.				
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Maryland 21215-0036	id be filed ental Hyg ked othe ic avent,	To Be C	17. Father's Name (First, Middle, Last) Willis Fridell Lillie Lee Holm														
lary	and and sem		19a. Informant's Name/Relationship (7)		_						Town, State, Zip Code) hevy Chase, MD 20815			20015			
	l and lealth em 27 ther to		Monique Fridell / 20a. Method of Disposition	Daughte									nevy i			20013	
Jor	nt of the		1 ☐ Burial 2 X Cremation 3 ☐ F		1 9	Place of Dispo cemetery, cres										inia	
Baltimore,	permit. Pages Department of t Important: If ite any injury or of		21. Signature of Funeral Service Licens			Comfo 1296 51	2. Name an	d Addres	s of Facilit	y Jose	eph Gawl NW, Wa	Ler'	s Son	s, 1	Virg: [nc. 20016		
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	ittending Ph death. ctor: After th y the funeral		27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year) 28b. Tin			of 28c. Injury at Work? M 1 Yes 2 No				28d. Describe how injury occurred						
Division	Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certificately filled in by the funeral director, tely filled in by the funeral director.	Certification;	3 Suicide 6 Could not be 4 Homicide determined								itreet and Number or Rural Route Number, n. State)						
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	- 04	nte.	Peter Hamm, M.D. 31 Date filed (Month, Day, Year)	5530 Wi 32. Regi	SCONS strar's Signa	atura 🚓	di		_	Chase	e, MD	2081	5				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Louise S. Geib Jan 2004 7:45 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Oeath 4c. County of Death Examiner GENESIS ELDERCARE-THE PINES EASTON TALBOT 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day, Year) APR 22 1914 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 ☐ M 2 🗓 F MARYLAND Director 216-18-2682 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10d. Inside City Limits r than "natural", or Items 23a or 28a-f shov the Madical Examinar must be natified at 1√ Yes 2 No TALBOT EASTON Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 DUTCHMANS LANE 21601 IISA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE Completed by 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME . Pages 1 and 2 should be filed w frient of Health and Mental Hygies tant: if item 27 is marked other to jury or other traumatic event, In 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN JESSE MULLIGAN SKINNER ETHEL BENSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT M. CATTANEO 7768 WOODLAND CIRCLE, EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State WOODLAWN MEMORIAL PARK 01-06-2004 `4 ☐Donation 5 ☐ Other (Specify) EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 JOHN K. MERC 23a. Part1. Enter the disease, or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner heroscienosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit Oue to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? β 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy certificate ha 2) 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ this 28a. Oate of Injury (Month, Day Year) Manner of Oeath 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral 6 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL D. CROWLEY M.D. 508 IDLEWILD AVE., EASTON, MD 21601 31. Date filed (Month, Day, Year)

JAN 0 5 2004 State Registrar

		•	1 - For State Registrar		State o	f Ma	rylan		artment rtificate			and N	lental Hy	giene Reg. No	/ 11	04	015	37
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- 2	Funeral		5. Social Security Number	6. S		7. Age	(In yrs. I	last birthday)	If Under	1 Year	If Under		8. Date of Bir	th		9 Birthr	lece /Stete or Fo	oreign
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	pur *		Usual Residence of Decedent 10a. State 10b. Cour	ntv			10c. City	y, Town or Lo	cation								I0d. Inside City L	imits
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	28e-	rect	10e. Street and Number						10f. Zip	Code				10g. Cit	izen of W	Vhat Cour	ntry?	
	h with	<u>=</u>	183 Ravine S	tree	t						2153	5			US	SA		
336	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28e-f show event, tre Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ M 3 ☑ Widowed 4 □ Divorce		12. Was Dec Armed F 1 Yes If Yes, G Year or D	orces? 2 📉 No ve			Was Deced If Yes, spec 1 ☐ Yes 2		spanic Ori n, Mexicar Specify:	gin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	-		k, White,	can Indian, etc. hite	
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and	ould be fi Mental H arked ott atic ever	Be	17. Father's Name (First, Midd Joseph Knopsi	_								a Dw		, Maluen	Surnam	10)		
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	12 a		Doris M. Bea		•				-					-			MD 2153	6
altimore,	es 1 au of Hea of Heam fitem r othe	- 10	20a. Method of Disposition				20b. P	lace of Dispo emetery, crei	sition (Nam	ne of ther place	9)	1	Date	20c. L	ocation -	City or To	own, State	
E	Peges nent of int: If it iry or o		1 X Burial 2 ☐ Crematic 1 4 ☐ Donation 5 ☐ Other			State		dison (8,	2004	Add	lisor	n, PA	1	
Balt	permit. Peges Department of Important: If i any injury or o		21. Signature of Funeral Servi		uma	لىع							s, P.A. ntsvill					
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×	Examiner			-				uence of): DMY FO	R ADEI	NOCA	RCINC	OMA					26 DAYS	
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	10		30. Name and address of pers	on who														
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D		-	For State Registrar	State of Maryla		artment of H			ene 2001	01538
	-84		Decedent's Name (First, Middle, Last)					2. Date of Death	Day Year	3. Time of Death
- Age	Physicia		Diana Le	ee	Grubb			January	3^{4} , 200^{4}	0740 A M
	/Medic Examin		4a. Facility Name (If not institution, give str 6000 Block Garrett	eet and number) Highway		4b. City, Town, or Oakland		h	4c. County of Dear Garrett	th
M.	Funeral		5. Social Security Number 6. Sex 1 Number 6. Sex	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		(ear) Co	thplace (State or Foreign buntry) arvland
e e	Director	-	Usual Residence of Decedent	40				Dali. 20,	1937 Pic	ilylanu
	land ow		10a. State 10b. County	10c. C	City, Town or Lo	ocation				10d. Inside City Limits
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	the 28s	Je C	10e. Street and Number			10f. Zip Code		109	g. Citizen of What Co	puntry?
	3a or	<u> </u>	7876 George Washing	gton Highway	y		21550		USA	
	ns 2	era		. Was Decedent Ever in		Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S	Specify Yes or No-	14. Race - Ame	
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9	tied within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Items 23a or 28a-f show ent, the Medical Exam per must be notified at	Completed	15. Decedent's Educa (Specify only highest grade of	tion	16a. Dece	dent's Usual Occup	ation during most of wo	orking 10	6b. Kind of Business	/Industry
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<u> </u>	Ment Ment arke	ဥ	Jesse		oss		Ellen	*****		ittinger
a	2 sh and is m		19a. Informant's Name/Relationship (Type	•		1		ural Route Number,		
2	and ealth m 27		James H. Grubb/hus				asningto	n Hwy., O	aktand ; Md Oc. Location - City or	
ore	of H If its		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer		cemetery, crei	osition (Name of matory or other place				
Ē	Pag ment ant: ury c		* 4 □ Donation 5 □ Other (Specify)]		w Cemeter	-	7/2004	Oakland, l	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or Items 23a or 28a-f show eny injury or other traumatic event, the Medical Example in ust be notified at angle.		21. Signature of Funeral Service Licensee	A		2. Name and Addre		Stewart Fu		e
	40 = a		23a. Part1. Enter the disease, or complica	Garal				Oakland,M		Approximate
	Physician /Medical Examiner	Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	cause on each line.	PLE I	Muris				Interval Between Onset and Death
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Vital Records, P	9 P 99	δ	Part II. Other significant conditions control	nbuting to death but not re	esulting in the u	inderlying cause giv	en in Part I.	23e. Did toba	1	o the cause of death?
000	w requir been si should	ompieted						24a. Was an	24b. Were a	utopsy findings available
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⋚	Physician: this certific ral director.	O B	examiner?	spital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA Oth	er	Home 5 ☐ Resider		city) At Scene
ō		-	27. Manner of Death	28a. Date of Injury (Month, Day Year)	-			28d. Describe hov		TROLLA
on	tending death. tor: After the funer	tio	1 □ Natural 5 □ Pending 2 ☑ Accident investigation	1-3-04	Injury	AM 1	Yes 2 No	Deiven	OFCIDA, 14P	SCHUITH TRATOR
Division	after death. after death. I Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe				28f. Location (Stre	eet and Number or R State)	ural Route Number,
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	To the Hospital or Att. within 24 hours after de To the Funeral Direct completely filled in by t	ledical C		cian: To the best of my ker: On the basis of examinand manner stated.				e, and due to the cau	use(s) and manner a	s stated.
	o the o the omple	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Mon	th, Day, Year)
)	F 3 ⊢ 8		> floquite 1	nethele	un	O.C.M			anuary 4,	
		0,	30. Name and address of person who com	pleted cause of death (It	tem 23a) (Type	111 Penn	Street,	Baltimore	, Maryland	d 21201
	St: Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar Sig	nature	South	ø.			

			For State Registrar	. 10000	State of	Marylar		artmen rtificat			and M	lental Hy	giene Reg. No	Z U	4 01	539
			1. Decedent's Name	(First, Middle, La	ist)							2. Date of De Month	Da	v Yes	3. Time	of Death
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	Examir		4a. Fecility Name (If							Location	of Death		i	County of De		
			Frederick					Fre If Under	deri	ck If Under	24 Hrs	0.0		rederi		
2	Funeral Director		5. Social Security No. 215-03-03		Sex 1 □ M 2 🛣 F	. Age (In yrs.	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da December	in y, Year) 20	1914 Ma	Birthplace (State Country) ryland	or Foreign
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	ylanc		10a. State	10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside	
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	item de	nue.	11. Marital Status	ed 2 Married	12. Was Deced	ces?	1.5.	If Yes, spec	cify Cuba	n, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)	-	Black, W		
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Z	should ind Men in marke umatic	2	19a. Informant's Na		-		19b. Maili	na Address	(Street a			al Route Numb	er, City	or Town, State	, Zip Code)	
Z	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural; or itema 23a or 28a-f ahow any injury or other traumatic avent, the Medical Examiner must be notified at 2008.		Thomas Gu		(1),20,1111,			-				Airy,				
ē,	f Hea item		20a. Method of Disp	position		20b.	Place of Dispo					Date		•	or Town, Stete	
Ę	Page lent o nt: If ry or			☐Cremation 3 [5 ☐Other (Speci	Removal from S	1210	spect				anuary	9,2004	Mt.	Airy,	Maryla	nd
Baltimore,	permit. Departm Imports any inju		21. Signature of Fu	neral Service Lice	nsee	-//		2. Name an							omes, P	
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	the a	yslc	1 ☐ Yes 2 0 9 ☐ Unknown	No	4∐Pregna 9☐ Unkno	int at time of o	death 5	Other (sp	овсту) <u> </u>							
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Records,	uires sign ld be	d b	Den	rentia	J							1 🗆	Yes 2	□ No 3 □	Probably 4	Inknown
00	w rec	iete										24a. Was		24b. Were	autopsy finding	s available
Re	The law te has lage 2 s	Completed by				, , , , , , , , , , , , , , , , , , , ,						auto perfe	psy ormed? 2D/No	death		cause or
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_	To the Hospitel or Attanding Physician: within 24 hours after death. To the Funarel Director: After this certification completely filled in by the funeral director.	ical C	29a. Certifier (Check only	Certifying P	hysician: To the	sis of examin	owledge, deat ation and/or in	h occurred ivestigation	at the tim	ne, date ar pinion, dea	nd place, ath occurr	and due to the	cause(s) and manner d place, and c	as stated. lue to the cause	(s)
	To the hwithin 24	Medical	one) 29b. Signature and	title of certifier	and mann	er stated.		290	c. License	number			29d. Da	te signed /Mo	onth, Day, Year)	
	F 3 F 8)	XILAN					\	7-709	5			1/6/0		
	1		30. Name and addr	ess di personali	Scompleted cause	of death (Ite	m 23a) (Tvoa		V 4	, , , ,				1010	1	
	H		DWV CT-	THU NOT	WEN, K	MD , 15			nTOL	m p	IKE	FRED	eni	CK, M	D2170	2
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	Regist	rar		1/831 _ 6	200%	Maner	w.	0	Ann	21/2	plan to					

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 L Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** CHARLES BURTON GLOVER January 4, 2004 2:20 PM /Medical 4e Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Buckingham's Choice Frederick Adamstown 8. Date of Birth (Month, Day, Y Apr. 30, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Oklahoma 5. Social Security Number 6. Sey 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Deys 442-16-2754 80 Vrs Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Frederick Director Adamstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3200 Baker Circle 21710 U.S.A. Funeral 12. Was Decedent Ever in U,S. Amed Forces? 1 ∰ Yes 2 □ No If Yes, Give Year or Detes: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ANO Specify: Specify: ۾ 3 Divorced 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FBI U.S. Government 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Julius Carmen Glover Arliss Burton 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Richard Glover (Son) 9909 Ritchie Drive, Ijamsville, Maryland 21754 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State Smithsburg Crematory 1/6/04 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ROBERT CHARGE SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Pert#. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical METASTATIC CARCINOMA weok, Examiner Due to (or as a consequence of): OF ORO PHARYNX monk Examiner CARCINOMA ettending physicien end for use es the burial-transit or Attanding Physician: The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? t∐Yes 214No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 27. Menner of Death 28b. Time of Injury 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Tertifying Physician. To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier within 24 hor To the Fune completely fi (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert D- 31912 TAD 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) opossum raun Pine, FREDERICH 1564 JULY MELOUP, MD 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		-	1 = For State Registrar		State of	Marylan	-			ealth a			eg. No.	2004	0154
	Physici	an	Decedent's Name (First, Middle	, Last)		000	TO A A AT					2. Date of Deat	Day	Year	3. Time of Death
3	/Medic	al	FLORENCE 4a. Facility Name (If not institution	aive etc	eat and numb		DMAN	4h City	Town or	Location of	of Death	JANUARY		2004 County of Dea	6:00P N
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-	Funeral		5. Social Security Number	6. Sex		. Age (In yrs.		If Under	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Dey	Yeer)	9. Bir	thplace (Stete or Foreig
	Director		578-01-5886	1 🗆 N	4 2 🔀 F	9	1 Yrs.	Months	Days	Houis	1	DEC 4, 1	912	MAĬ	RYLAND
7	* *	}	Usual Residence of Decedent 10a. State 10b. County			10c. Cit	v. Town or Lo	ocation							10d. Inside City Limits
	f sho	ō	MARYLAND MONTGO	MFRY		POT	OMAC								1 □ Yes 2 No
-	288	Director	10e. Street and Number	лыкт		101	01110	10f. Zip	Code			1	0g. Citiz	zen of What C	ountry?
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	SEE	Funeral	11. Marital Status	12	Armed Ford		.S. 13.	Was Dece If Yes, spe	dent of H	ispanic Ori n, Mexicar	gin? (Spe	cify Yes or No- Rican, etc.)	1	14. Race - Am Black, Whi	
9	or It	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced		1 ☐ Yes 2 If Yes, Give Year or Dat			1 🗌 Yes	2 ∑ No	Specify:				Specify: \[\text{\chi}	WHITE
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	h and h and 7 is m		19a. Informant's Name/Relations LINDA ROSE/DAUG					3				I Route Number	-		
	Health Health em 27		20a. Method of Disposition			20b. F	Place of Dispo	osition (Na.	me of	1		-		cation - City o	
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			21. Signature of Funeral Service		/	12020						MEMORIAI			
ă	Departition Depart		A CALLANTON				11	170 R	OCKV	ILLE :	PIKE:	, ROCKVI	LLE	, MARY	LAND 20852
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,00/00	fricate be executed py physician and to the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. d.	ARTHR	ETIS or as a consec	quence of):								
	the death certifically the attending phiched for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	230	1 Live bir	ome of pregnath 2 ☐ Feta ant at time of d	al death 3	⊒Ectopic p ⊒ Other (s		<u>'</u>			2	23d. Date of de Month	alivery Day Year
ν, Γ	quires that the de in signed by the a uld be detached f	Completed by Pl	Part II. Other significant conditi	ons conti	ributing to dea	ath but not res	sulting in the (underlying	cause giv	en in Part I					to the cause of death? Probably 4 XIUnknow
S L L	The faw requi											24a. Was a autops perform	SV	24b. Were a prior to death?	
VII	ysician: Th is certificate director, pag	Be	25. Was case referred to medica examiner?		spital:				OA Oth	or		(Check only or			
5	S D	٠ <u>۲</u>	1 ☐ Yes 2 🔀 No 27. Manner of Death	110	1 🗀 in	patient 2 [ER/Outpatie		UA	4 LA INI		me 5 Residence R			ecity)
	ding h. After fune	E G	1 Natural 5 ☐ Pendi	ng igation	28a. Date of (Month	, Day Yeer)	Injury	м	28c. Injur Wor 1 🗍	k? Yes 2∐				,	
=	tor: the	Certification:	3 Suicide 6 Could 4 Homicide deterr	not be	28e. Place o	of Injury - At h g, etc. (Speci	ome, farm, si	reet, facto	ry, office			28f. Location (S City or Town			Rural Route Number,
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	12		1	UN	TOWN	M			D3	5792			JANU	ARY 3,	2004
	1.		30. Name and address of person DR. SWAROOP G.						T D	OCKUT	T.T.F	ΜΔΡΥΙΛΙ	JD.	20852	
tr. "			DR. SWAROOP G. 31. Date filed (Month, Day, Year			gistrar's Sign		DVTA	ı, K	OCKVI	, ظبرند	MAKILM	עי	20072	
	St Regist	ate	JAN 0 7			مصرده.		1	1 1 m : 1 d	,					

Certificate of Death

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	Funeral Director	
	pur *	

rthan "natural", or Itams 23a or 28a-f shov the Medical Examinar must be notified at with the Maryl death filed within 72 hours after permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, If and once

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

The law requires that the death certificate be executed as the burial-transi the attending physician and Box 68760, esn detached for Division of Vital Records, P.O. signed by pe been certificate the funeral director, this After Hospital or Attending death. hours after death unaral Director: filled in by

10/5/1

GRAFF

CITO

2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 5, 2:54 PM January 2004 Otto Graff 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Montgomery Suburban Hospital Bethesda If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Months 1**∑**M 2□F 152-20-9712 78 Yrs. 1925 New Jersey Nov. 11, Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 No Johnson City Tennessee Washington Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 37604 United States 1501 Strawberry Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 XIYes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara Langweiler Otto Graff, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Raymond O. Graff/Son 4231 Charley Forest Street, Olney, Maryland 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) January 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery 2004 Bethesda, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Crematorium, Inc. 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenu M01353 Bethesda, Maryland 20814-3501 21. Signatura of Funeral Service Licensee Wisconsin Avenue 1 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition DASTRI 6 Tears resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine resulting in death) Last Due to (or as a consequence of): Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 Yes 2 Mo 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ☐ ER/Outpatient 1 Tes 2 No 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 1 PCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number IMPLIAND DSIGIE 05 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DINA #327, OLNEY, MD 20832 NELSON

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 09 2004

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ORIGINAL

32, Registrar's Signature

DA.	P	•	For State Registrar	State of Maryland	•		t of Heal		•	giene Reg. No.	2004	01543
	Physicia	an	Decedent's Name (First, Middle, Last)	21100		-			2. Date of De Month	ath Day	Year	3. Time of Death
,	/Medic		Natasha Gr. 4a. Facility Name (If not institution, give st	aves		4h. City.	Town, or Loca	ation of Death	JANUAR'		County of Death	1:32a M
	Examin						verly	ation of Boatin			cince Ge	
	Funeral		Prince George's Hos 5. Social Security Number 6. Sex	7. Age (In yrs. la:	st birthday) Yrs.	If Under Months	1 Year If U	Inder 24 Hrs. Durs Min.	8. Date of Bir (Month, Da			nplace (State or Foreign
	Director		579 96 1218 114 Usual Residence of Decedent	21	115.				10/3	1 / / 0	ЪС	
	and w	1	10a. State 10b. County	10c. City,	Town or Lo	cation						10d. Inside City Limits
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	with a or	ā	511 Harry Turi	man Drivo			2077	1		ī	JSA	,
	eath	Funeral		2. Was Decedent Ever in U.S.	. 13. V	Vas Dece			ecify Yes or No	_	14. Race - Amei	ncan Indian,
	Itarr	ä	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕱 No	II	Yes, spe	offy Cuban, Me	exican, Puerto	ecify Yes or No Rican, etc.)		Black, White	
36	urs af	ğ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	∐ Yes	2 √ 2 No Sp	ecify:			Specify:	Black
ğ	be filed within 72 hours after death with the Maryland tal Hyglene. did phyglene "natural", or itams 23a or 28a-f show other than "natural", or itams 23a or 28a-f show event, the Medical Evandrat must be notified at	ed	15. Decedent's Educ	ation			al Occupation			16b. Kir	nd of Business/f	ndustry
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	and 2 ealth a n 27 i		Sylvia Bazemor	e Mother	511	Har	ry Tu	rman I	Drive	Uppe	r Marl	lboro,Md
Je Je	of He Itam		20a. Method of Disposition	cer	ce of Disport	sition (Name	ne of ther place)		Date	20c. Lo	cation - City or	Town, State
Ĕ	Pages nent of int: If Its		1 ☐ Burial 2 ☆ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	Riv	erda	le P	ark	01/1	12/04	Riv	erdale	e,Md
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If Itam 27 is marked sny injury or other traumatic e ones.		21. Signature of Funeral Service License	9	22	Snea 1409	d Mor Fair	facility tuary lakes	Servi Pl St	ce,F e B	Mitche	ellville,MI
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ó	be executed sician and burial-transit	EX	resulting in death) Last	Due to (or as a conseque	ence of):							
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89	tifica ng ph as th	Med	IE EEN IN E									
Вох	leath certific attending pl	Physician/Me	230. was decedent pregnant	3c. If yes, outcome of pregnan- 1 ☐ Live birth 2 ☐ Fetal o		Ectopic p	regnancy			2	3d. Date of deli	,
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æ	The lay	6								ormed? 2 ☐ No	death? 1 □ X es	
亞	ician: Th certificate rector, pag	Be C	25. Was case referred to medical				26.	Place of Deat	h (Check only	-		
>	Physician: r this certific ral director,	ToE	examiner? XXYes 2 □ No	ospital: 1 ☐ Inpatient 2 🖔 E	R/Outpatien	t 3 D	OA Other: 4	☐ Nursing Ho	me 5 Res	idence 6	Other (Spec	cify)
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Division of Vital Records,	al or Attan after deat Diractor: d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide	28e. Place of Injury - At hon building, etc. (Specily)	ne, farm, str	eet, factor	y, office			Street and wn, State,		ral Route Number,
	To the Hospital or Attanding Physician: The within 24 hours after death. To the Funaral Diractor: After this certificate his completely filled in by the funeral director, page	edical C		ician: To the best of my know ter: On the basis of examination								
	To the within 2 To tha complet	Me	29b. Signature and title of certifier			29	c. License nur	mber			signed (Month	* '
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	3	1	30. Name and address of person the co	mpleted cause of death (Item :	23a) (Type,	Print)			144	3.0		01201
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	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	La La	1	arks					
	Regist	ar	14M (131 / HII)	G AFFE	/~/	JUNE !	Mary and the state of the state					

	Registrar			Cer	tificate	e of C	Death			Reg. No	. 200	14 0	154
_	. Decedent's Name (First, Middle, Last)								2. Date of Month	Death Da	ay Yee		of Death
cian	Iluminado	N.	Garc	ia							2004		:15 a M
ical iner ⁴⁸	a. Fecility Name (If not institution, give s				4b. City, 1	Town, or I	Location of	f Death		_	. County of D		
III4CI	10414 Glenmore Dri	ino			۸۵۵	lphi				Dw	inas C	1	_
5.	Social Security Number 6. Sex		e (In yrs. la:	st birthday)	If Under	1 Year	If Under 2		8. Date of	Birth	9.1	eorge: Birthplace (State Country)	te or Foreig
4		M 2□F	72	Yrs.	Months	Days	Hours	Min.		Day, Year			
	Isual Residence of Decedent		1 4						March	1,17.	31 Pu	erto Ri	co
11	0a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside	City Limits
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	Maryland Prince Ge Oe. Street and Number	orge's		Ade1p	10f. Zip	Code				10g C	itizen of What	Country?	
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_	10414 Glenmore Dri			1		207					USA		
e 1	1. Marital Status	12. Was Decedent I Armed Forcas?		i. 13. V	Was Deced f Yes, spec	dent of His city Cuban	spanic Orig 1, Mexican,	jin? (Spe , Puerto	ecify Yes or Rican, etc.)	No-		merican Indiar /hite, etc.	•
	1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 ☑ 1 If Yes, Give	No		1 ☑ Yes 2	2□ No	Specify:				Specify:		
1 px	3 Widowed 4 Divorced	Year or Dates:					Puert	to R	ican			hite	
Completed	15. Decedent's Educ (Specify only highest grade	cation		16a. Deced	ient's Usua kind of wor	of Occupat	tion	of worki	ina	16b. F	Kind of Busine	ss/Industry	
ם	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. L	DO NOT us	se retired)	· · · · · ·		9				
0	5	30 (1	,	Const	ructi	ion I	Worke	r			Constru	ction	
	7. Father's Name (First, Middle, Last)								e (First, Midd	lle, Maidei	n Sumame)		
o Be	Maniana Carria								27.0				
	Mariano Garcia 19a. Informant's Name/Relationship (Ty)	no Print)		10h Mailin	a Addross	/Ctroot or			Nieve		or Town, State	a Zin Cadal	
	isa. informants Name/Aelationship (19)	pe, mini	4	190. Mailin	ig Address	(31/66/ 4/	ng Number	i oi nuis	ai moute ivuii	iber, City	or rown, state	e, zip code)	
	Martha R. Garcia	Wif		10414			Driv					20783	
	0a. Method of Disposition 1	lomoval from State	20b. Pla	ace of Dispo metery, cren of H	sition (Nam natory or ot	ne of ther place)		Date	20c. L	ocation - City	or Town, State	
	'4 □Donation 5 □Other (Specify)	emoval from State	Gate	e of H		ı eterv		[an	5 2004	041.		W.	
2	21. Signature of Euneral Service License	99 /)		22	. Name and	d Address	s of Facility	au.	2,2004	STT	zer spr	ing,Ma	ryran
	1 2 2	()		Fr	ancis	J.	Colli	ns l	Funera	1 Hon	ne, Inc		
	23a. Part1. Enter the sease, or compli	Le la	the death	Donotoni	U Uni	vers	ity B	Lvd	.,W.,S	ilvei	_Sprin	Approxi	
	shock, or heart failure. List only on	ne cause on each lin	ne.	DO HOL OHL	er the mous	ia or aying	, such as c	Saluac C	or respiratory	arrest,		Interval	Between nd Death
	Immediate Cause (Final disease or condition	D											IG DOMIN
	disease of condition	. Prosta	ite Ca	ncer									220
	resulting in death)	Due to (or as	ate Ca a conseque									4 ye	ars
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	resulting in death)		a conseque	ence of):									ars
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			1 _ State		epartment of Health and M	lental Hygier	1e 2001. 01516
			Registrar		Certificate of Death	Reg. N	
	Physici	ian	Decedent's Name (First, Middle, Last,)			3. Time of Death
	/Medi		Mauricio	Guevarra		January	1,2004 4:05 AM
	Examir	ner	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		c. County of Deeth
			Holy Cross H	USPITU	JIVE Spring		Montgomery
	Funeral		5. Social Security Number 6. Set	M 2DE	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	
	Director		None Usual Residence of Decedent	0 4	2 07	Jan. 1, 2	004 Maryland
	land		10a. State 10b. County	10c. City, Town o	or Location		10d. Inside City Limits
	Mary Feb	tor	Maryland Montgom	Cd lyo	r Spring		1 ☐ Yes 2 🖾 No
	28a	rec	10e. Street and Number	ery	10f. Zip Code	10g. (Citizen of What Country?
	within 72 hours after death with the Maryland one. than "natural", or Itame 23a or 28a-f show the Madical Examinar must be notified at	by Funeral Director	12514 Epping Cour	• +•	20906		USA
	me 2	era	11. Marital Status		13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
ယ	of Ita	Fur	1 X Never Married 2 ☐ Married	1 ☐ Yes 2 🔀 No			Black, White, etc.
93	al', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 M Yes 2 No Specify: Salv	adoran	Specify: White
21215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation 16a. D	ecedent's Usual Occupation Give kind of work done during most of working	16b.	Kind of Business/Industry
2	thin of the	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	fe. DO NOT use retired)	·9	
21	filed wi Hygien Sther th	Con	None		Never Worked		N/A
pu	ould be filed with Mental Hygiene. arked other than atic avent, than	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Maide	en Sumame)
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. If the lith and Mental Hygiene. Item 27 is marked other than "natural", or Itame 23a or 28a-1 show item 27 is marked other than "natural", or Itame 23a or 28a-1 show other traumatic avent, I'm Medical Examinar must be invitted at	2	Franklin Mauric		Elvia F	uentes	
lar	2 sho and Is m		19a. Informant's Name/Relationship (Ty	rpe, Print) -Father 19b. N	Mailing Address (Street and Number or Rura	I Route Number, City	or Town, State, Zip Code)
	1 and Health em 27		Franklin Mauricio	Guevarra 1	2514 Epping Court, S		
ore	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	isposition (Name of crematory or other place) Theaven Janua 20	oate 20c.	Location - City or Town, State
Ē	ortant: If it	١.	* 4 ☐ Donation 5 ☐ Other (Specify)	Cer	metery 20	004 Si	lver Spring, MD
Baltimore,	permit. Pages 1 and Depritment of Health Important: If item 27 any njury or other tr	117	21. Signature of Funeral Service Licens	00/	22. Name and Address of Facility Francis J. Collins	Funeral Ho	ome Inc
=	40 = 3 d		Mulligue par	109	Job university Bivd	. W., Silv	ver Spring, MD 20901
			23á. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death. Do not ne cause on each line.	enter the mode of dying, such as cardiac o	r respiratory arrest,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Placental A	pruptop		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of)	7 1 0	(4)	
74	Cxammer		Sequentially list conditions.	Premature Preti	erm Mupture of	Membro	ines 2hours
	P #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of)			
	and tran	саш	that initiated events resulting in death) Last	3. Burn to (1995)			
760,	ate be executed hysicien and he burial-transit		Todaning in down, Last	Due to (or as a consequence of):			
687	ate t	dicai		d			
9 X	leath certificat attending phy I for use as the	Physician/Med	IF FEMALE:	10- 4			
Вох	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of delivery Month Day Year
o.	t the de by the a tached t	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant at time of death 9⊡ Unknown	5 Other (specify)		,
Ω.	The law requires that the death certifica lie has been signed by the attending ph age 2 should be detached for use as th		Part II. Other significant conditions con	ntributing to death but not resulting in th	ne underlying cause given in Part I	23a Did tobacco	use contribute to the cause of death?
ds,	signe b ad b	by		who was the same of the same o	to underlying oddoo groot in 1 art 1.	1 ☐ Yes	•
0	w require been sig should b	etec				1 103	Z I TODADIY 4 JOHANOWII
Records,	e law has t	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
		Ö				performed? 1 ☐ Yes 2 ☐ N	death? 1 Yes 2 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	leaster.	26. Place of Death	(Check only one)	
of	this al dii	P	1 1 162 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	lospital: 1 Inpatient 2 ER/Outpa		ne 5 Residence	
n C	ding P h. After funer	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Tim	ry Work?	28d. Describe how inj	ury occurred
Sic	ittendi death. ctor: A / the fu	cat	2 Accident investigation 3 Suicide 6 Could not be	an Blood in	M 1 Yes 2 No		
Division	or Al	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	281. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		201 Cartina ATI Cartinian Bhu	alaine. To the best of 1000			
	Hos 24 ho Fund fely f	Medical	29a. Certifier 1	ner: On the basis of examination and/o and magner stated.	leath occurred at the time, date and place, a or investigation, in my opinion, death occurre	ind due to the cause(and at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
	thin 2 the the	Mec	29b. Signature and title of continer	and marrier stated.	29c. License number	29d D	ate signed (Month, Day, Year)
	To To		1	A WIND	1112 / CI	/	1/0/04
7		1			1 17567K	2	1/8/0
			30. Name and address peren who co	IFAGE	pe, Print)	Silvand	Same molargia
	C+-	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	vics7 gien 1/000	- Oliver	abrud in Braid
	Sta	132	15 5 A C 200	a Aure 9	South		•

			1 - For State Registrar	State	of Marylar		artment of H Tificate of		Mental Hyg	giene 2001	01547
	Dhi.:		1. Decedent's Name (First, Middi	e, Last)					2. Date of Dea Month	th Day Yeer	3. Time of Death
	Physici /Medio		Clarence F.	Hall S	r.				Januar		1:30 p™
	Examir	er	4a. Facility Name (If not institution	7				r Location of Dea	th	4c. County of Death	
			Chesapeake Ho	Spice H		In ma finishing along a	Linth:		5 0 Day -4 Disab	Anne Aru	
	Funeral Director		5. Social Security Number 212-16-4894	6.5ex 1⊈M 2□F	7. Age (In yrs. 84	Yrs.	Months Days	Hours Min		(Year) Cou	place (State or Foreign intry) yland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	cation				10d. Inside City Limits
	Many field	ţ	Maryland Anne	Arunde	1 An	napol:	S				1 ∑Yes 2 ☐ No
	r 28a	Directo	10e. Street and Number	. III allac		парот	10f. Zip Code		1	10g. Citizen of What Cou	intry?
	23a c		29 W. Washing	ton Str	eet Ap	t. 209	214	101			ISA
	tems rems	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U forces?	J.S. 13. 1	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Amer Black, White	
36	s afte	by F	1 ☐ Never Married 2 ☐ Mar 3 ② Widowed 4 ☐ Divorced	ned 15 Tyres If Yes, G	2□No live Dates: 194	1-16	1⊡Yes 21XINo	Specify:		Specify: B	lack
2-003	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "naturel", or items 23e or 28e-f show event, I're Medical Evanifier must be nuffied at	ed	15. Deceder	t's Education		16a, Dece	ient's Usual Occup	ation		16b. Kind of Business/li	ndustry
215	hin 7. 9. 9n "na Medi	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed	(1-4or 5+)	(Give	kind of work done OO NOT use retired	during most of wo d)	orking		,
2	filed wit Hygiene other the	Con	8th	0		Chie	ef Cook			US Naval i	Academy
Maryland	uld be filk fental Hy rked oth tic event	Be	17. Father's Name (First, Middle,						me (First, Middle,	,	
$\frac{8}{2}$	should be nd Mental marked o	ဥ	Frederick			405 14-10-			ces John	 	
<u>B</u>	d 2 sho th and 7 is m	1	19a. Informant's Name/Relations Pamela Harris		tor)	i				r, City or Town, State, Zi	
	s 1 and 2 should if Health and Mer item 27 Is marke other treumetic		20a. Method of Disposition	(Daugii	20b. i	Place of Dispo	sition (Name of			OCK , AR 72 20c. Location - City or T	
Ê	Pages nent of int: If it iry or o		PDBurial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (S			ryland meters	atory or other place Vetera	in 1/8	/04		113
altimore,	permit. Pages 1 Department of H Important: If ite any injury or otl once.		21. Signature of Funeral Service		ice.	22	. Name and Addre	ss of Facility		Crownsvil	Le, Ma.
m	8 8 2 6		Lavy Di		00483	Wr 82	<u>l West</u>	St. An	napolis	ary, P.A. Md. 2140)1
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the dear	th. Do not ent	er the mode of dyin	ig, such as cardia	c or respiratory arr	est,	Approximate Interval Between
2	Physician	4 4	Immediate Cause (Final disease or condition resulting in death)	_am	elarlo	eler	Course	2)			Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):	a Ta				
		ē	Sequentially list conditions,	b. — Due to	(or as a consec	quance off.	ourse	^			
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	S	Co Con	lean	el				
ĵ	an an rial-tr	Еха	resulting in death) Last	Due to	(or as a consec	quence of):	,				
8760	icate be executed physician and s the burial-transit	dlcal		d							
٥		Med	IF FEMALE:	22 1/							
X R R	it the death certifi by the attending lached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregn birth 2 □Feta nant at time of c	al death 3 [Ectopic pregnancy Other (specify)	,		23d. Date of deliv Month	ery Day Year
o.	the de	iyslo	1 □ Yes 2 □ No 9 □ Unknown	9□ Unkr		1ea(ii 5 _	Other (specify)				
J.	de de	by Ph	Part II. Other significant condition	ons contributing to	death but not res	sulting in the ur	iderlying cause giv	en in Part I.	23e. Did to	pacco use contribute to t	he cause of death?
Vital Records,	w requires been sign should be								1 □ Y€	es 2 ☑No 3 ☐ Prol	oably 4 □Unknown
ပ္က	aw re as bee 2 sho	Completed							24a. Was a	n 24b. Were auto	opsy findings available impletion of cause of
Ĭ	m <u>r</u> o	mo:							autops perform	ned? death?	
/Ita	sicien: The certificate rector, pag	Be (25. Was case referred to medica examiner?				197		ath (Check only on	в)	
0	this aldi	T _o	1 Yes 2 No	Hospital: 1 🗆	Inpatient 2			4 🗀 Nursing F	dome 5 ☐ Reside		vittospice
	ding P. h. After funer	tlon	1 ☑Natural 5 ☐ Pendir	ng (Mor	nth, Day Year)	28b. Time of Injury	28c. Injun Worl	yat k? Yes 2 □ No	28d. Describe no	ow injury occurred	
Division	al or Attendi after death. I Director: A d in by the fu	fica	3 ☐ Suicide 6 ☐ Could	not be	e of Injury - At h	ome, farm, str	eet, factory, office		28f. Location (St	reet and Number or Run	al Route Number,
É	spital or ours after ours after ours after ours after ours filled in b	Certification;	4 Homicide	build	ling, etc. (Specia	fy)	,		City or Town	n, State)	
	호 는 글 후	Medical C	29a. Certifier 1 Certifyir (Check only one)	Examiner: On the I	e best of my kno basis of examina nner stated.	owledge, death ation and/or inv	occurred at the tin	ne, date and place pinion, death occ	e, and due to the caurred at the time, da	ause(s) and manner as s ate and place, and due to	tated. o the cause(s)
	To the within 2 To the Complet	Mec	29b. Signature and title of certifie		mor stated.		29c. License	e number	2:	9d. Date signed (Month,	Day, Year)
	->-0		· Carles 1	tarrin	uno		1)5	53306		1/6/04	
			30. Name and address of person	who completed cau	se of death (Iter	m 23a) (Type,		,	4	1 -1 -1	
			Curfys /tarr		SS 8 1	305/94/	c Rd SI	te 211 1	Annapolis	3 MO 21	1401
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0	7 2004	Registrar's Signa	K A	hord				

			For State	State of	f Maryland / D	epartment of Certificate o			2001.	0151.8
			Registrar 1. Decedent's Name (First, Middle, L.	ast)		or timeate o	Death	2. Date of Death	g. No. 4	3. Time of Death
	Physici		Audrey	Delo	arie	Harv	017	Month	Day Year	
	/Medic		4a. Facility Name (If not institution, gr				, or Location of Deat		6, 2004 4c. County of Deat	11:35 A M
	Examin	er	18151 Garrett Hi		,,,,	45. Oky, Town	0akland	''		" rrett
	Funeral				7. Age (In yrs. last birth	day) If Under 1 Ye	ar If Under 24 Hrs			
	Director		214-36-6996	1□M 2⊠F		rs. Months Day	rs Hours Min.	(Month, Day,) Mar. 2,		hplace (State or Foreign untry)
	ס		Usual Residence of Decedent					1101. 29	I J JO N N S	ryland
	nylan how		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Ma Ma	ç	MD Ga	rrett		- 0	akland			1 ☐ Yes 2 ☑ No
	th the	Director	10e. Street and Number			10f. Zip Code	•	100	g. Citizen of What Co	untry?
	23a		18151 Garrett H	ighway			21550		USA	
	tems	Funerai	11. Marital Status	12. Was Dece Armed For	dent Ever in U.S.	13. Was Decedent of If Yes, specify C	f Hispanic Origin? (S uban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
36	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28e-f ahow he Wedical Examiner must be notified at	by Fi	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Giv	9	1 ☐ Yes 2 ☒ N	lo Specify:			nite
8	hour turel	8	15. Decedent's 8	Year or Da		ecedent's Usual Occ	unation	146	25 Kind of Business	
Ω	in 72	Completed	(Specify only highest gi	ade completed)	(Give kind of work dor ife. DO NOT use ret	ne during most of wor	king	6b. Kind of Business/	industry
7	with lene.	E	Elementary/Secondary (0-12)	College (1-	-4or 5+)	05.73	ner		Ceramic S	Th on
Ö	Hyg Hyg other	Be C	17. Father's Name (First, Middle, Las	1)		OW1		ne (First, Middle, Ma		мор
Maryland 21215-0036	lid be lental ked ic ev	To B	Charles	M. M	Nin	er	Cora			Bucklew
a _Z	shou and N amar umat	_	19a. Informant's Name/Relationship	(Type, Print)				ral Route Number, C	City or Town, State, Z	
Ž	alth a 27 is		Larson G. Harvey	/husband					, Md. 2155	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28e-7 ahow eny injury or other traumatic event, the Medical Evantiner must be notified at once.		20a. Method of Disposition		20b. Place of D	Disposition (Name of crematory or other p			c. Location - City or	
Ë	Page Nent c nt: If ry or		1 ☑ Burial 2 ☐ Cremation 3 ['4 ☐ Donation 5 ☐ Other (Special Control of Con		state	rk Cemete:		0./2004	Deer Park.	**********
<u>=</u>	mit. partin porta y inju		21. Signature of Funeral Service Lice	Uto6	Deer ra	22. Name and Add		STREET, STREET	neral Home	
m	88 5 8 8		Product	Down		32 S. Se			Md. 21550	
			23a. Part1. Enter the disease or con shock, or heart failure. List only	plications that ca	tused the death. Do no	t enter the mode of d	ying, such as cardiac	or respiratory arrest	t,	Approximate Interval Between
. 0	Enysician	0	Immediate Cause (Final disease or condition		monia					Onset and Death
	/Medical		resulting in death)		or as a consequence of):				2 weeks
	Examiner		Sequentially list conditions,	b. Emph	ysema					vears
	ם ד	iner	if any, leading to immediate cause. Enter Underlying	Due to (d	or as a consequence of	:			- 3	
	and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	C						
60,	cate be executed ohysician and the burial-transit		,) or eoc	or as a consequence of					
8760		dicai		_ d						
×	death certifi e attending id for use as	Physician/Me	IF FEMALE:	23c. If yes, outc	ome of pregnancy				204 Date of date	2.7
Box	atter for u	clar	23b. Was decedent pregnant in the past 12 months?	1 Live bir	rth 2 Fetal death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)	су		23d. Date of deliver Month	Day Year
o.	the sche	ysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unkno	wn	(,,,),			ļ	
J.	The law requires that te has been signed b page 2 should be deta	by PI	Part II. Other significant conditions	contributing to dea	ath but not resulting in t	ne underlying cause (oven in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
Records,	w require been sig should b							1 <mark>g</mark> ⊋Yes	2 □ No 3 □ Pro	babiy 4 🗆 Unknown
ပ္တ	awre s bec 2 sho	Completed						24a. Was an	24b. Were aut	opsy findings available
ř	The lav	ШО						autopsy performe 1 ☐ Yes 2 🛭	d? death?	ompletion of cause of
Vital	10	BeC	25. Was case referred to medical				26. Place of Dea	th (Check only one)	100 100	20140
	ysici iis ce direc	To E	examiner? 1 ☐ Yes 2 🏹 No	Hospital: 1 ☐ In	patient 2 ER/Outp	atient 3 DOA	thor		e 6 □Other (Speci	ify)
0	ng Ph ter th neral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of	f Injury 28b. Tin , Day Year) Inju			28d. Describe how		
<u> </u>	Attending Physician: r death. ector: After this certific by the funeral director,	atic	2 ☐ Accident investigation	n			☐Yes 2☐No			
Division	I or Attendater deatl Director:	Certification;	3 ☐ Suicide 6 ☐ Could not to determined	200. Place (of Injury - At home, farm g, etc. <i>(Specify)</i>	, street, factory, office	9	28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
	Hospital or te hours afte Funeral Dir tely filled in I			1						
	ne Hospital n 24 hours ne Funeral bletely filled	Medical	29a. Certifier 1 ★ Certifying P (Check only one) 2 ★ Medicel Exa	piner: On the base and manner	best of my knowledge, o sis of examination and/o er stated.	leath occurred at the or investigation, in my	time, date and place, opinion, death occur	and due to the caus red at the time, date	se(s) and manner as a and place, and due t	stated. to the cause(s)
	To the within 2 To the I complet	Σ	29b. Signature and title of certified			29c. Lice	nse number	29d.	Date signed (Month,	
•						D	23979		01/08/200	4
			30. Name and address of person who	completed cause	of death (Item 23a) (Ty	rpe, Print)		1		
			Robert A. Goral		. 311 N. H	ourth St.	, Oakland	Md. 2155	50	
	Sta Registra		31. Date filed (Month, Day, Year) JAN 0		gistrar's Signature	1. 10.				
	negisti	A1	5/117 0 (2007	الر ماليون	A DOMEST				

			1 - For State Registrar	State of Ma		partment ertificate				iene	104	01	549
	Physici /Medic		Decedent's Name (First, Middle, Last) OLENA AUDREY HAHN					-	2. Date of Dear Month JANUARY	th Day	Year 004	3. Time of 6:25	Death P ^M
	Examir		4a. Facility Name (If not institution, give s DENNETT ROAD MANOR	NURSING		OAK	Down, or Location			4c. County	of Death		
	Funeral Director		5. Social Security Number 6. Sex 218-60-1508	/. Age	(In yrs. last birthdi Yrs	Months	Days Hour	der 24 Hrs. s Min.	8. Date of Birth (Month, Day, DEC 31,	Year) 1916	9. Birthpl Count WV	ace (State o try)	r Foreign
	th the Maryland or 28e-f show a notified at	Director	10a. State 10b. County MD GARRETT 10e. Street and Number	<u> </u>	10c. City, Town or	Location KE PARK 10f. Zip C			1	0g. Citizen of		od. Inside Cit 1 \(\overline{A}\)Yes try?	•
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It item 27 is marked other than "natural", or items 23e or 28e-f show it item 27 is marked other than "natural", or items 2 is notified at or other traumetic event, the Madical Examinar must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ② N If Yes, Give Year or Dates:		3. Was Decede If Yes, specif			ecify Yes or No- Rican, etc.)		ce - America ck, White, e y: WH		
121215-0	filed within 72 ho Hygiene. pther than "naturi ent, the Wedical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12		(G.	cedent's Usual ve kind of work b. DO NOT use HOMEMAK	done during m retired) ER		ng		HOME	ustry	
ryland	should be fi ind Mental H s marked otl umetic ever	To Be	17. Father's Name (First, Middle, Last) FRANCES OBADIAH II		405.44		CYN	THIA	CATHERIN	NE MACK	LEY		
Sre	permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun once.		19a. Informant's Name/Relationship (Ty, CYNTHIA CARR - DAU 20a. Method of Disposition 1 [XBurial 2 □ Cremation 3 □ Ric 4 □ Donation 5 □ Other (Specify) 21. Signal to 9 Furnical Service License	GHTER	20b. Place of Discometery, of	O BRIE position (Name rematory or oth MEMORIA 22. Name and	N ST. of pr place) L GARD Address of Face	MT. L	04	MD 2 20c. Location - OAKLANI BOX 243	1550 City or Tov	vn, State)
	cate be executed // Medical Examiner // Medical the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. List of Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	the death. Do not e	enter the mode	of dying, such	as cardiac o				Approximate Interval Betw Onset and D	veen
P.O. Box 68	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	Fetal death	B⊟Ectopic preg i⊟ Other (spec				23d. Dat	e of deliven	•	ear
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions conf	tributing to death bu	t not resulting in the	underlying cau	se given in Par	t I.		acco use conti		cause of de	
		Completed							24a. Was an autopsy perform	ed?	Were autops prior to compleath?	sy findings a pletion of ca	vailable use of
Division of Vital	To the Hospital or Attending Physicien: The within 24 Hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day		of 280	Other: 4 🕅 I Injury at Work? 1 🗆 Yes 2 [Nursing Hon 2	(Check only one ne 5 ☐ Resider 8d. Describe hov	nce 6 Othe			-
DIX	spital or Attene ours after deatl ieral Director: filled in by the		4 Homicide determined		y - At home, farm, s (Specify)			1	8f. Location (Stre City or Town,	State)			er,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier (Check only one) 1	er: On the basis of e and manner state	examination and/or	investigation, in	my opinion, de icense number	eath occurre	d at the time, dat	use(s) and mai te and place, a d. Date signed	and due to the	he cause(s)	
•	6		30. Name and address of person who con	npleted cause of dea	Qu De ath (Item 23a) (Type		154		J	ANUARY	7, 20	004	
	Sta Registra		P. DANIEL MILLER, 31. Date filed (Month, Day, Year)		WOLF ACE		E	OAF	CLAND, M	D 21550)		

			r	'lease I					. Ensure A	_		gible.		
			For State		State of M	aryıanı		artment of r tificate of	lealth and N			006	015	50
			Registrar	Adirbello Logal			Cei	unicate of	Dealli	2. Date of Deat	g. No	0 0 4	3. Time of Di	leath
	Physicia	an	Decedent's Name (First,	Middle, Last)						Month	Day	Yeer	0058	
	/Medic		Arthur		Jackson			Hanlin	or Location of Death	Jan.	3	unty of Death	0038	5
	Examin	er	4a. Fecility Name (If not ins	1.1	1.1	coil	. i	\wedge	,	4	40.00	N ii	C	
			5. Social Security Number	Hear 6. Sex		SPIT	ast birthday)	If Under 1 Year	1 ber lar	8. Date of Birth	ļ		Gany place (Stage or F	Foreian
ı	Funeral Director		220-26-9609		M 2□F	73	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Oct. 18,	^{Year)} 1930	Cou	ntry)	
	pur *	}	Usuel Residence of Decede			10c. City	, Town or Lo	cation					10d. Inside City	Limits
	aho	5							1				1 ☐ Yes 2	
	788-f	ect	MD 10e. Street and Number	Garı	ett			Oak1a	nd	11	On Citizen	of What Cou	ntry?	
	with a or	ᡖ	567 Kings I	Dun Por	o d			Toi. Zip Gods	21550		9. 0	USA	,	
	death with the Maryland ima 23a or 28a-f ahow r must be notified at	Funeral Director	11. Marital Status		12. Was Decedent	Ever in U.	S. 13. ¹	Was Decedent of H		pecify Yes or No-	14.	Race - Ameri	can Indian,	
	iter d	표	1 ☐ Never Married 20		Armed Forces? 1 ☑ Yes 2 ☐ If Yes, Give	,			Hispanic Origin? (Sp an, Mexican, Puerto	o Rican, etc.)		Black, White,		
93	urs a	þ	3 Widowed 4 Div		If Yes, Give Year or Dates:			1 ☐ Yes 2 ☑ No	Specify:		Sp	ecify: Wh	ite	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiens. I Health and Mental Hygiens. I have the marked other than "natural", or I tame 23a or 28a-f ahow other traumatic avent. It a Medical Examiner must be notified at	Completed	15. De (Specify only	cedent's Edu	cation		16a. Dece	tent's Usual Occup	pation during most of work	kina	16b. Kind	of Business/In	dustry	
213	within 7 ene. than "r	g	Elementary/Secondary (College (1-4or	5+)	life.	DO NOT use retire	d)	g				
2	ed wi	5			2			Milita				ir Fore	c <u>e</u>	
pu	tal Hid doth	Be	17. Father's Name (First, M	liddle, Last)					18. Mother's Nam	ne (First, Middle, M	Maiden Sui			
yla	2 should be filed within and Mental Hygiene. Le marked other than aumatic event, Ire Mi	ဥ	Arthur	Hern		Han	lin		Georgia				phold	
Maryland	2 sh and le m raum		19a. Informant's Name/Rei						and Number or Ru				o Code)	
	of Health of Health Itam 27		Letha J. Har	ılin/wi	lfe	20h Pi			Road, Oa			1550 ion - City or To	own State	
0	r of F		20a. Method of Disposition 1 XBurial 2 ☐ Crem		emoval from State	1		sition (Name of natory or other pla				•		
altimore,	permit. Pages Department of the Important: If Its any injury or of	-	`4 □Donation 5 □Ot			Garı			Gdns. 1/6	/2004 _	0ak1	and, M	aryland	
Bal	permit Depar Impor any in		21. Signature of Funeral S	ervice Licens	1 AF			. Name and Addre	•	Stewart			ne	
	40= 40	_	23a. Part 1. Enter the disea	Jan N	MULK TO	d the death			ond St., (21550	Approximate	
			shock, or heart failure	e. List only or	ne cause on each i	ine.	L	-/	n ====================================		1	At	Approximate Interval Betwe Onset and De	en eath
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		1	ros	100		an cer	2	m	MJE	5 mg	MIL
1	Examiner		,		Due lo (or as	a consequ	ience of):							
.77		<u>-</u>	Sequentially list conditions	, E	Dua to (pras	a consequ	once of		· · · · · · · · · · · · · · · · · · ·					-
	ted nsit	Examiner	Sequentially list conditions if any, leading to infried at cause. Enter Underlying Cause (Disease or injury	*										
	be executed ician and burial-transit	xar	that initiated events resulting in death) Last		Due to (or as	a consequ	ience of):							
09,	eath certificate be exattering physician for use as the burian	E												
687	centificate Iding phys	olbe a												
	nding use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregna	2	3c. If yes, outcome			_			23d	. Date of deliv	ery	
Вох		Cal	in the past 12 months 1 Yes 2 No		1□Live birth 4□Pregnant a]Ectopic pregnanc] Other <i>(specify)</i> _	у			Month	Day Yea	ar
P.O.	that the dead by the detached	Jysi	9 Unknown		9 Unknown					,		1000		
		y PI	Part II. Other significant co	onditions cor	tributing to death t	out not resu	Iting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	acco use	contribute to t	he cause of dea	ath?
g	requires een sign tould be	Q D	seve	Ve 1	ane	ny	1			1 □ Ye	s 29N	io 3 ☐ Prol	oably 4 □Uni	known
Vital Records,	> 0 %	Completed by	n	Roll	line					24a. Was a		4b. Were auto	opsy findings av	allable
Re	0 - 0	E C								autops: perform	ned?	prior to co death? 1 ☐ Yes	mpletion of cau	ise of
ta	icien: Th	0	25. Was case referred to m	nedical					26. Place of Dea	th (Check only one		1 103	2010	
>		To B	examiner?	H	lospital: 1 Napati	ent 2 🗆	ER/Outpatier	nt 3 DOA Ott		ome 5 Reside		Other (Special	fy)	
of	g Phys ter this neral di		27. Manner of Death		28a. Date of Inju	ury Voarl	28b. Time o	28c. Inju Wo	ry at	28d. Describe ho				
Division	별으호호	atlo	1 Natural 5 1 2 Accident	Pending nvestigation	(North, De	y (62)	itijory		Yes 2 □ No					
Vis	Atte	ific		Could not be determined	28e. Place of In	jury - At ho tc. (Specify	me, farm, sti	eet, factory, office		28f. Location (Str. City or Town	reet and N	umber or Rura	al Route Numbe	ar,
Ö	s after s all Dir	Certification:			Junuary, C	ici (opcony	,			,	,			
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	dical							me, date and place					
	ha H in 24 he Fi plete	0	one)	Juicai Czailii	and manner s		ion and on in	vestigation, in my	opinion, death occu					
	To T	Σ	29b. Signature and title of	certifier	1 +		117	29c. Licens	se number	CG 25	od. Date s	igned (Month,	Day, Year)	
•			> V (X	1 per	4 1	VL1_	ノ	0 34	7		7/0	4	
			30. Name and address of p	erson who co	mpleted cause of	death (Item	23a) (Type,	Print)	Driv	10 /	2 11	ushou	-land	6.
								CO +hin						a AVII
		2	31. Date filed (Month, Day,		1 1 1 1 1	ra s Signa	OL	seton	17170	, (- 1	MUCI	1000	1

James Hadra 04-00269 crn

cm			artment of Health and	Mental Hygie	ne 2001 01551
	1 - State Ragistrar	Ce	rtificate of Death	Reg.	No. 2004 01551
Physicia	Decedent's Name (First, Middle, Last)				Day Yeer 3. Time of Death
/Medica	James Minton Hadra		10 Ci T 1 1 1 1 1 1		7:15 P M
Examine	Gunther Hotel	na number)	4b. City, Town, or Location of De	ath	4c. County of Death
Europe	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Frostburg If Under 1 Year If Under 24 H	's. 8. Date of Birth	Allegany
Funeral Director	463-44-5608 N⊠ M 2□		Months Days Hours Mi		
g	Usual Residence of Decedent			15-5ep-170	16,43
urylar show	10a. State 10b. County	10c. City, Town or Lo	peation		10d. Inside City Limits
8a-f	Maryland Allegany	Frostburg			1 ▼ Yes 2 No
vith th	1 10e. Street and Number	Street	10f. Zip Code	10g.	Citizen of What Country?
s 234		Daniel Control	21532-	U.S	
1215-0036 within 72 hours after death with the Maryland ene. then "neturel" or Hems 28a or 28a-f show ha Madical Examiner must be indiffed at	Armo	Decedent Ever in U.S. and Forces? Yes 2 No	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	Specify Yes of No- into Rican, etc.)	14. Race - American Indian, Black, White, etc.
215-0036 thin 72 hours all le. "neturel; or	3 ☐ Widowed 4 ☐ Divorced Year	s, Give	1 ☐ Yes 2 ☑ No Specify:		Specify: White
2-0 72 ho	15. Decedent's Education	16a. Deced	dent's Usual Occupation	16b	. Kind of Business/Industry
New Year	(Specify only highest grade completed Elementary/Secondary (0-12) Colleted Collete	ege (1-4or 5+)	kind of work done during most of w DO NOT use retired)	orking	
d 21 filed will Hygien sther the	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) 12 8	profe			ngvage department
be fill the dott	17. Father's Name (First, Middle, Last)		18. Mother's N	ame (First, Middle, Maid	den Sumame)
Maryland d 2 should be file th and Mental Hy if is marked oth traumetic svent	Jack Ernest Hadra			Louise Minton	
Mai d 2 st th and 7 te n traun	19a. Informant's Name/Relationship (Type, Print Winifed Redick	estate executor 54 Bec	ng Address (Street and Number or F		
e, N 1 and Health em 27 ther tr	20a. Method of Disposition	20b. Place of Dispo	Fro	ostburg Date 20c	Maryland 21532- Location - City or Town, State
Itimore, it. Pages 1 au utment of Hea ntant: If item njury or othe	1 ☐ Burial 2 X Cremation 3 ☐ Removal		natory or other place)		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or items 23a or 28a-1 show eny injury or other traumetic event, tha Madical Examination in Milled at once.	* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funerat Service Is ansee		Name and Address of Facility	-3d1-2004 C01	mberland Maryland
Balt permit. Depart imports eny inj	John & Well	- 17	urst Funeral Home, 57	Frost Ave Fros	thura MD 21532
	23a. Part1. Enter the disease, or complications t shock, or heart failure. List only one cause	hat caused the deeth. Do not ent-			Approximate
Physician	Immediate Cause (Final disease or condition	T. An Lose se	Aternal to	01 =0 1	Interval Between Onset and Death
/Medical	resulting in death)	e to (or as a consequence of):	WIT TOUS COMPACE	NEAL SVOJOULO	~ Mistige
Examiner	Sequentially list conditions b.	V			
executed in and ital-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	e to (or as a consequence of):			
ecute and trans	Cause (Disease or injury that initiated events resulting in death) Last				
68 760, cate be executed physician and the burial-transit		e to (or as a consequence of):			
18760, icate be executed physician and the burial-transit	d				
P.O. BOX 6 nat the death certification of by the attending letached for use as	IF FEMALE: 23c, If yes	s, outcome of pregnancy			
BOX leath cert attendin if for use	23b. Was decedent pregnant in the past 12 months?	ive birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
by the a	1 Yes 2 No 9 Unknown 9 U	Jnknown	one (speed)		
		to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
Hecords, he law requires t e has been signe tge 2 should be o				1 🗆 Yes	2 No 3 Probably
The law required has been so page 2 should				24a. Was an	24b. Were autopsy findings available prior to completion of cause of
r 9 4 8		autopsy performed?	opath/		
ysician: 1 ysician: 1 is certificat director, p	25 Was case referred to medical		26. Place of De	ath (Check only one)	165 2 100
- S D	Y Yes 2 No Hospital:	1 Inpatient 2 ER/Outpatient	t 3 DOA Other: 4 Nursing	Home 5 Residence	6 X Other (Specify) at scene
ding Ph. After th funeral	27. Manner of Death 28a. Dending	Date of Injury 28b. Time of Injury Injury	28c. Injury at Work?	28d. Describe how in	
or Attending or Attending lifer death. Director: After in by the fune	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No		
UNISION C tal or Attending P is after death. al Director: Atter t ed in by the funera	4 Homicide determined 28e.	Place of Injury - At home, farm, stre pullding, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ite)
spital ours ours illed		o the hest of my knowledge, death	occurred at the time, date and plac		
the Hosp in 24 hou the Fune pletely fil	(Oneck only 2 Medical Examiner: On the and	ne pasis of examination and/or inv manner stated.	estigation, in my opinion, death occ	urred at the time, date a	nd place, and due to the cause(s)
DIVIS To the Hospital or Attu- within 24 hours after de To the Funeral Directo completely filled in by the	29b. Signature and title of certifier	^	29c. License number	29d. D	Date signed (Month, Day, Year)
8	1 Clack of M	4)	O.C.M.E.	Jar	nuary 11, 2004
	30. Name and address > person who completed	cause of death (Item 23a) (Type, F			
nas	J. LAHAN Lock	altimore, N	Maryland 21201		
State	31. Date filed (Month, Day, Year) JAN 1 2 2004				
Registrar	ALM T M C004	" una 19	South		

		1	1 - For State Registrar	State of Ma	arylan		artment rtificate			and M		giene Reg. No. 20	04	01552
	Physici	20	1. Decedent's Name (First, Middle, Last								2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic		FLORENCE MODES				45 00 7		1	4 D 15	JAN	4 20	004	12:30 a ^M
	Examin	er	4a. Fecility Name (If not institution, give SHADY GROVE AD)		нові	ΡΤͲΔΤ.	,	own, or	Location o	of Death		4c. County		
	Funeral		5. Social Security Number 6. Se			last birthday)	If Under 1	1 Year	If Under		8. Date of Bir	th		DMERY thplece (State or Foreign puntry)
<	Director		192-12-2317	⊒м 2 Х Г	81	Yrs.	Months	Days	Hours	Min.	SEPT 7	1922	Co	PA
	pc a		Usuat Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation							10d. Inside City Limits
	Aaryla f aho	ō	MD MONTGO	MERY		RMANTO								1 ☐ Yes 2 X No
	1880-	rect	10e. Street and Number				10f. Zip (Code				10g. Citizen of	What Co	ountry?
	h with	ai Di	18421 KINGSHIL	L ROAD			2	087	4			US	3A	
	deat	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U	.S. 13.	Was Decede	ent of His	spanic Orig	gin? (Spe	ecify Yes or No		ce - Ame	erican Indian,
36	hours after death with the Maryland tural; or Rems 23a or 28e-f ahow al Examinant by multipal at	Completed by Funeral Director	1 Never Married 2 Married	1 ☐ Yes 2 💢 N If Yes, Give	lo		1 ☐ Yes 2		Specify:		,		fy: WH	
21215-0036	hour tural	ed b	3 Widowed 4 Divorced 15. Decedent's Edi	Year or Dates:		16a Decer	dent's Usual	Cocupa	tion			16b. Kind of B	Lusinass	Andustry
15	within 72 ene. than "na!	piet	(Specify only highest grad		4)	(Give	kind of work DO NOT use	k done d	urina most	t of worki	ng	TOD. INITIO OF D	43111033	industry
213	giene giene er tha	Com	Elementary/Secondary (0-12)	4	- ,	REGIS	STERE	DN	URSE			HEALI	'H C	ARE
pu	be filed tal Hygi d other avant, I	Be	17. Father's Name (First, Middle, Last) CASIMIR KASABA									Maiden Sumar		
<u> </u>	should be nd Mental marked o	ဥ		(max (Delay)		105 14-75		(0)				CHAELS		7.0.13
Maryland	d 2 Tha		PATRICIA HALE—		AUGI		6798					er, City or Town R CEN	TER	VILLE, VA
	permit. Pages 1 end. Department of Health Important: If Item 27 any injury or other tr		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nam	e of	T		ate	20c. Location		121 Town, Stete
Ē	Page nent o unt: #		1 ☐ Burial 2 ☐ Cremation 3 🔀 1 14 ☐ Donation 5 ☐ Other (Specify,		MT.		ET C			/7/	04	CARVER	TON	, PA
Baltimore,	permit. Departr Imports any inju		21. Signature of Funeral Service Ligens	500			. Name and				IOME			
	20559		23a. Part1. Enter the disease, or comp	M			ILTO					LLE. M	lD -	20838
			shock, or heart failure. List only o	one cause on each lin	the deat	n. Do not ent	1	1	, such as	cardiac c	r respiratory a	rrest, *		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. 50	10 p		Sho	CY	2					6 weeks
	Examiner			Due to (or as a	2	riell	Ci	C	epr	2;	an	1		
		ner	if any, leading to immediate	Due to (or as					1		9()			
	and trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		une	em	ice						
8760,	The faw requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	icai E	, saaming in soam, and	Due to (or as	1	a a b	Con	nih	0	1	1 lec	hion		
687	ficate physics the	edic	~	d	(, ,	443	CCII		-(1	, ,	1			
Box 6	eath certific attending p	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Je					23d. Da	ite of deli	ivery
œ.	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pre Other (spe					Mo	onth	Day Year
P.O.	at the d by the	Physician/Medi	9 Unknown		-									
JS,	uires that the de signed by the a id be detached f	by	Part II. Dther significant conditions co	He no	Posi	uiting in the ui	nderlying ca	use give	n in Part I.					o the cause of death?
Sor	w requir been si should	etec	Morbid	obe	6.1									
Re	sician: The law certificate has b irector, page 2 s	Completed	7(0. 3.61	0.50		7						rmed?	prior to death?	topsy findings available completion of cause of
tal	an: T tificati tor, pa	0	25. Was case referred to medical						26. Place	of Death	(Check only of		1 🗌 Yes	2 No
<u> </u>	lysici lis cer direc	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	nt 2 🗆	ER/Outpatien	t 3 DO	Othe				dence 6 □Oth	ier (Sper	cify)
0	ng Ph Iter th meral	on:	27. Manner of Peath 1 ☐ Watural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year)	28b. Time of Injury	28	c. Injury Work				now injury occur		
sio	tendi seath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be	00 - Di (Ini			М		'es 2⊡ñ	-				
Division of Vital Records,	datter of Direct	Certification:	4 Homicide determined	28e. Place of Injubulding, etc	. (Specif	ome, tarm, str y)	eet, factory,	office			City or Tov		er or Hu	iral Route Number,
_	spitations and analytical	a C	29a. Certifier 1 Certifying Phy	sician: To the best of	of my kno	wiedge, death	occurred a	it the timi	e, date and	d place, a	and due to the	cause(s) and ma	anner as	stated.
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funaral Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only 2 Medical Exam	iner: On the basis of and manner sta	examina	tion and/or in	estigation,	in my op	inion, deat	th occurr	ed at the time,	date and place,	and due	to the cause(s)
	Not To t	Σ	29b. Signature and title of certifier	T	i .	110		License				29d. Date signe	d (Monti	/
	7		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	~ D	(40			354			01/	04	12004
	3		30. Name and address of person who c	ompleted cause of d	eath (Iten	1 23a) (Type, M. D.	Print)	ha	cly	Gra	o u.e	Hosp	i he	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	ır's Signa	iture	4		1	14	OC RO	ille -		lang knot
15	Registr	ar	JAN -	6 4004	DA		O	1	CA	1				

			1 - For State Registrar	State of		nd / Depa		t of H	ealth a	and Ment	al Hygie	ene o	04	0155	3
	Dhoriei		1. Decedent's Name (First, Midd								te of Death		V	3. Time of Death	, T
	Physici /Medio		JEANETTE B							JA	NUARY	^{Day} 2	0 0 4	7:04 p	М
	Examir	er	4a. Fecility Name (If not institution						Location	of Death		4c. County			
			Frederick Mem 5. Social Security Number	·	ital 7. Age (In yrs.	last hirthday)	F're	deri	C K If Under	24 Hrs. 8. Da	te of Birth	Frede			
	Funeral Director		230-09-1747 Usuel Residence of Decedent	1□M 2₩F	86	Yrs.	Months	Days	Hours	Min. (M	ch 16,	1917		olece (Stete or Foreightry) ginia	ign
	nylanc how		10a. State 10b. Count			y, Town or Lo							1	0d. Inside City Limit	its
	e Ma	ctor	Maryland Fre	derick	W	alkers	ville							1 XYes 2 N	10
	th with th	ai Director	10e. Street and Number 56 W. Frederic	k Street			10f. Zip	^{Code} 2179	3		10g	U.S.A		ıtry?	
900	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or iteme 23a or 28a-f ehow event, it a Mudical Exertiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	If Voc Cine	ces? 2 No		Was Deced if Yes, spec			gin? (Specify Yo , Puerto Rican,	es or No- etc.)		, White,	ean Indian, etc. white	
5-0	72 ho	etec	15. Decede (Specify only highe	nt's Education est grade completed)		16a. Deced	ient's Usua kind of won	l Occupa	tion	t of working	161	o. Kind of Bus	iness/In	dustry	
121	within ine. ihan	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)			e retired		t of working		a	ъ		
7	Hygid ther int,		17. Father's Name (First, Middle	Last)		Secr	etary		18 Mothe	r's Name (First,	Middle Mai			artment	
rylan	should be filed vind Mental Hygies marked other tumatic event.	To Be	Benjamin Frank	lin Nash					Li	zzie Go	uldmar	1			
, Mai	and 2 sh ealth and m 27 is n		Steven Balders			1204	0akwo	od D	rive,	Freder	ick, N	ity or Town, S Iarylar	itate, Zip 1d Z	Code) 21701	
Baltimore, Maryland 21215-0036	Pages 1 nent of H int: If ite		20a. Method of Disposition 12□ Burial 2 □ Cremation 14 □ Donation 5 □ Other (3)			lace of Dispo emetery, cren Linco				Date ./6/2004		entwoo	•	_{wn, State} Iaryland	
Balti	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other treumatic events.	0 0	21. Signature of Funeral Service	Annual Service Licensee										: 21and 2170	02
			3a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate	
	Physician		Immediate Cause (Final disease or condition	-	0515									Onset and Death	
	/Medical		resulting in death)		oras a consequ	uence of):			-				-	Days	
	Examiner	_	Sequentially list conditions, if any, leading to immediate												
	per isit	cai Examiner	if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to (o	r as a consequ	uence of):							1		
_	al-trar	xan	that initiated events resulting in death) Last	c. Due to (c	r as a consequ	uence of):					_		-		-
68760,	sicien Sicien	aiE	Due to (or as a consequence of):												
.89	g phy as the			0.					_						
.O. Box	that the death certificate be executed ed by the attending physicien and detached for use as the buriat-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		th 2 Fetal nt at time of de	death 3 [Ectopic pre Other (spe					23d. Date Monti		ry Day Year	
ص	The law requires that the title has been signed by thoage 2 should be detached.	y Ph	Part II. Other significant conditi	ons contributing to dea	ath but not resu	ulting in the un	iderlying cai	use givei	n in Part I.	23	e. Did tobaco	o use contrib	ute to th	e cause of death?	
rds	quires n sign		Acute Re	ral Fo	ilure	2					1 🗆 Yes	2 No 3	☐ Proba	ably 4 🗆 Unknown	n
Records,	law requires as been si 2 should l	Completed	Acrtic	Stanosis						24	a. Was an	24b. We	ere autor	sy findings available	e
		E O									autopsy performed Yes 2	? de	or to com ath?] Yes	pletion of cause of	
Viital	ysicien: Th	Bec	25. Was case referred to medica examiner?						26. Place	of Death (Chec	-	NO I	1185	140	
5	hys this at dia	2	1 ☐ Yes 2 No	Hospital:		ER/Outpatient		and the same of the same of	4	sing Home 5(Residence	6 Other	(Specify		
Division of	ding Ph h. After th funeral	ion:	27. Manner of Death 1 Alatural 5 □ Pendir	9	Injury , Day Yeer)	28b. Time of Injury		c. Injury Work			scribe how in	Jury occurred	i		
Sic	I or Attendi after death. Director: A I in by the fe	icat	2 Accident investi	not be	f laiuns . At he	ma farm -1	M		es 2 N						
2	after Dire	Certification:	4 ☐ Homicide determ	building	f Injury - At ho g, etc. (Specify)	et, ractory,	OTICE		City	or Town, St	and Number ate)	or Hurai	Route Number,	
	Hospital	aic	29a. Certifier Certifyin	ng Physician: To the b	est of my know	wledge, death	occurred at	t the time	, date and	place, and due	to the cause	(s) and mann	er as sta	ted	-113
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	(Check only 2 Medical one)	Examiner: On the bas and manne	is of examinat	ion and/or inv	estigation, i	п ту орі	nion, death	occurred at the	e time, date a	and place, and	d due to	the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifie	ŗ			29c.	License	number		29d. l	Date signed (Month, D	ay, Year)	
	11		MTE	Viso N	2		m		5161		1	5-04			
	4		30. Name and address of person	^	of death (Item	23a) (Type, F		_ 1	_	- 0		A . C		2170-	
	CV		31. Date filed (Month, Day, Year)) 2 Rec	nistrar's Sinner	Duite	2 2	×+	, r	redes	ick,	VUL)	21702	4
S.	Stat Registra		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 147 & Taney Ave Suite 20t, Frederick, MD 2702 31. Date filed (Month, Day, Year) JAN = 82004 > Aparts Sparks												

			For State Registrar Amend Item#24a				artment of He		nd Mental		_ /	74	01554
			1. Decedent's Name (First, Middle, Las		3828212	5/U44 5 W	inicate of b	Catiri	2. Date			V V	3. Time of Death
Н	Physicia	_	Mary Elizabeth						Janu		Day Y	ear	4:10 P ^M
	/Medic Examin	_	4a. Facility Name (If not institution, give		or)		4b. City, Town, or I	Location of [4c. County of		7.10.1
	LAGIIIII	-	16932 Annandale	Road			Emmitsb	urg			Freder	ick	
	Funeral		Social Security Number 6. S	ex 7.7	Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hours		of Birth h, Day, Ye	ear)	. Birthpla Counti	ice (State or Foreign
	Director		215-26-1887	□ M 2LOF	84	Yrs.			April	13,	1919 M	[ary1	and
	and	}	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10	d. Inside City Limits
	Maryi 1 sho	ō,	iaryland Freder	ick	Emm	itsbur	a '						1 ☐ Yes 2 ☐ No
	128a	rec	10e. Street and Number	ICK		LUSDUI	10f. Zip Code			10g	. Citizen of Wh	at Count	ry?
	filed within 72 hours after death with the Maryland Hygiene. sther then "natural", or Iteme 23a or 28a-f ehow ent, I'm Medical Erarumer must be notified at	Funeral Directo	16932 Annandale	Road			21727				USA		
	deat	ner	11. Marital Status	12. Was Deceder		S. 13.	Was Decedent of His f Yes, specify Cuban	panic Origin , Mexican, F	n? (Specify Yes Puerto Rican, et	or No- c.)	14. Race - Black,	America White, e	
တ္ထ	or It		1 Never Married 2 Married	1 ∐ Yes 2⅓ If Yes, Give	No		1 ☐ Yes 2√□ No	Specify:			Specify:	W	hite
ë	ural',	Completed by	3 Widowed 4 □ Divorced	Year or Date	s:	16a Dece	dent's Usual Occupa	tion		16	b. Kind of Busi		
5	n 72 n at	lete	15. Decedent's Education (Specify only highest graduation)	ide completed)		(Give	kind of work done di DO NOT use retired)	urina most o	f working	10	0. Tuild of Busi	no od ma	2011
7	filed withi Hygiene. other ther	mo	Elementary/Secondary (0-12)	College (1-4d	or 5+)	Sea	mstress				Tailor	ine	
Maryland 21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. Id other then "natural", or Iteme 23a or 28a-f show event, If a Medical Examiner must be notified at	0	17. Father's Name (First, Middle, Last,)				18. Mother's	s Name (First, N	liddle, Ma			
<u>la</u>	should be fand Mental he marked of	To B	Earl	E	Brown			Ida	Mae Bus	h			
<u>a</u>	s t and 2 should be filed withir f Health and Mental Hyglene. Item 27 ie marked other then other traumatic event, tra M		19a. Informant's Name/Relationship (ng Address (Street a						
	27 ≡ 2		Loretta Blevins/D	aughter	20h BI		2 Annanda.	Le Roa	ld, Emmi Date		rg, MD c. Location - C		
ore	Pages t ar		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from Sta	te Cé	emetery, crei	natory or other place	- 1	7-17				
altimore,	t. Partmen tant: njury		'4 □Donation 5 □Other (Specif		Bro		metery		9/2004		oxville		
Bal	permit. Pages Department of It Important: if ite any injury or of		21. Signature of Funeral Service Licer	gnature of Funeral Strivice Licensee 22. Name and Address of Facility 104 E. Main Stree									
	Sag Microsoft		23a. Parri. Enie III. disease,	plications that caus	sed the death		-			Approximate			
			sh o, or heart failure. List only Immediate Cause (Final	one cause on each	n line.	0	1	0-1					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or	as a consecu	uence of):	onary t	Succ	دعالا				
3	Examiner							10					
	T Ka	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Oue to (or	as a our soqu	aarioa of):							
	cuted nd ransi	Examiner	that initiated events	C									
Ö,	ate be executed hysician and the burial-transit	Ē	resulting in death) Last	Due to (or	as a consequ	uence of):							
8760,		dicai		_ d.		_							
Box 6	es that the death certific igned by the attending F be detached for use as	/Med	IF FEMALE:	23c. If yes, outco	me of pregna	ncy					23d, Date	of deliver	v
Bo	eath certifi attending for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth	n 2 □ Fetal t at time of de	Ideath 3[Ectopic pregnancy Other (specify)				Mont		Day Year
P. O.	the d y the iched	isku	1 ☐ Yes 2 Ø No 9 ☐ Unknown	9□ Unknow	n								
	s that ned b a deta	by Pi	Part II. Other significant conditions	-	A 27	- /		in in Part I.	23e	Did toba	cco use contrib	ute to the	a cause of death?
īds	w require been sig should b	ed b	Hypertens	ion, a	ridia	e Val	vular d	Mean	10	1 🗌 Yes	2 □ No 3	☐ Proba	ibly 4 ⊟Unknown
Records,	law requas been 2 should	Completed	Derpher	al wasci	Daz.	disco	ist,		24a	Was an autopsy	24b. We	ere autop	sy findings available
æ	The lav	E O					*		1 🗆	performe	d? de	ath? ∃Yes :	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?				7.0		of Death (Check	only one)			
> \	shysic this ce al dire	2	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inp		ER/Outpatie		4 🗆 Nurs			ce 6 Other)
n C	Jing P J. After 1 funera	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending		Day Year)	28b. Time o Injury	Work	rat (? /es 2.⊟No		cribe now	injury occurre	1	
Sic	Attending it death.	lcat	2 Accident investigation 3 Suicide 6 Could not to	De Jan Place of	Injury - At ho	ome farm st	reet, factory, office	103 2 11		tion (Stre	et and Number	or Rural	Route Number,
Division of	or A after Direct	Certification:	4 Homicide determined		, etc. (Specify		,		City	or Town, :	State)		
	spita nours nerai						th occurred at the time						
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	(Check only 2 Medical Exa	miner: On the basi and manne		tion and/or in	ivestigation, in my op	oinion, death	occurred at the				
	To the within To the comp	×	29b. Signature and title of smiller	3100	MAR		29c. License	number	50		I. Date signed	1	Day, Year)
)			1 challes	Suon	and of		500	200	2 1		-6-04		
	4		30. Name an indress of person who	7 . 6		n 23a) (Type	Print) PO	30X I	90	EMW	utsbu	29	UDZ1727
	Sta Regist		31. Date filed (Month, Day, Year)	7 2004 >	jistrar's Signa	ature	& do	arks.	/ -				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State	or mary	and / Dep	ertificate of	reaith and iv Death	ientai Hy	giene Reg. No.	6 (1111)	01555
H	Physicia	an	1. Decedent's Name							2. Date of Do	Day	7 2004	3. Time of Death 816 a M
	/Medic Examin	al	Anna 4a. Fecility Name (If	Mary Ho		number)		4b. City, Town, or	r Location of Death	Janua	- +	County of Deeti	
	LXamiii	Ci	110 Jeffe	erson Ro	oad			Waldor				CHarles	5
	Funeral Director		5. Social Security No. 577-52-27		Sex 1 □ M 2 X F		yrs. last birthda Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di	av. Year)	Co	hplece (State or Foreign untry) 1Sylvania
	and a		Usual Residence of 10a. State			100	. City, Town or	_ocation					10d. Inside City Limits
:	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do ther then "natural", or teme 23a or 28a-f ehow event, the Modical Examinal must be notified at	tor	MD	Charle	s		Waldorf						1 ☐ Yes 2 No
	or 28a	Director	10e. Street and Nun		y			10f. Zip Code			10g. Citi	zen of What Co	untry?
	23a c		2521 Lis	a Drive				20601				ted Sta	
	lteme Iteme	Funeral	11. Marital Status 1 ☐ Never Marrie	ad 2 Marrios	Armed	ecedent Ever Forces?	in U.S. 13	. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No Rican, etc.)	D-	14. Race - Ame Black, White	
030	urs aft	þ	3 Widowed		If Yes, O	s 2 X No Give Dates:		1 ☐ Yes 2 No	Specify:			Specify: Wh	ite
֝֝֝֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֓֓֓֓֓֓֓֓	72 ho	Completed	/Soec	15. Decedent's ify only highest	Education	d)	(Giv	edent's Usual Occup	durina most of worki	ing	16b. Ki	nd of Business/I	Industry
7	hen.	mple	Elementary/Secon		College	(1-4or 5+)	life	DO NOT use retired	4)		Ноз	1th Car	0
Maryland 21215-0036	filed v Hygie other t		17. Father's Name (First, Middle, La	2			Nurse	18. Mother's Name	(First, Middle	1		C
a a	lid be lental ked o ic eve	To Be	John J	. Friel					unav	/ailabl	e		
ary	ges 1 and 2 should be t of Health and Mental if Item 27 is marked o or othar traumatic eve		19a. Informant's Na		(Type, Print)			ling Address (Street	and Number or Rura	I Route Numb	er, City o		(ip Code)
	1 and 2 Health em 27 I		Margare		-daught	er		Lisa Driv					-
baltimore,	Pages 1 nent of H int: If ite iry or oti			Cremation 3				oosition (Name of ematory or other place		Date		cation - City or 1	
			* 4 □Donation 21. Signature of Full					tion Cemet		2-2004	CITN	ton, Ma	rylanu
n	permit. Departimport Import any inf		► Club	No M	Vetu	[a]	Н	22. Name and Addres untt Fune 1 . O. Box 15	ral Hóme 6 Waldor	f Mar	vland	20604-	-0156
	1000		23a. Pert1. Enter the	ne disease, or contract	emplications that	t caused the	death. Do not e	nter the mode of dyin	ig, such as cardiac c	or respiratory a	rrest,	2000	Approximate Intervat Between Onset and Death
F	hysician	9 8	tmmediate Cause (disease or condition	Final			al asp						Onset and Death
	/Medical Examiner		resulting in death)				nsequence of):	3					
		-	Sequentially list con	nditions,	b. Due t	o lor as a co	remuce of						
	uted d ansit	Examiner	cause. Enter Under Cause (Disease or that initiated events	injury 👕									
Ď,	e exec ian an irial-tr		resulting in death) L	ast	Due t	o (or as a co	nsequence of):						
09/89	ificate be executed g physician and as the burial-transit	edical		•	d								
χ O	= 0.61		IF FEMALE: 23b. Was decedent	program		outcome of pr					2	23d. Date of deli	very
Box	The law requires that the death cert te has been signed by the attendin, age 2 should be detached for use a	Iclan/M	in the past 12	months?	4□Pre	birth 2 🗌 gnant at time		☐Ectopic pregnancy ☐ Other (specify)				Month	Day Year
J.	at the by the	Phys	9 🗆 Unknown		9L Uni					1			
s,	res th signed be de	by	Part II. Other signifi	icant condition	s contributing to	death but no	t resulting in the	underlying cause giv	en in Part I.		robacco u Yes 2[the cause of death?
Ö	been should	eted								24a. Was		-	topsy findings available
He	The lav	ompleted								auto	psy ormed?	prior to c death? 1.25 Yes	ompletion of cause of
	(0)	e C	25. Was case refer	red to medical					26. Place of Death	1 (Check only		UZ F183	20 110
0 1	Physician: this certific al director,	To B	examiner? 1 XYes 2	No	Hospital: 1 (Inpatient	2 ER/Outpati	-	4 Nursing Hor				at scene
טעמ	ding Ph h. After th tuneral	inol	27. Manner of Death 1 □ Natural	5 Pending	E (M	te of Injury onth, Day Yea	ar) 28b. Time Injury	Worl	yat k? Yes 2 No	28d. Describe neck loc	how injun	y occurred	on bed and
DIVISION	after death after death Director:	ficat	2 Accident 3 ☐ Suicide	investiga 6 ☐ Could no determin	Jarries	ce of Injury	At home, farm, s	street, factory, office		28f. Location (Street and	d Number or Rui	ral Route Number,
	al or / s after il Dire	Certification:	4 🗌 Homicide	determine	bui		ted livin		ul .	110 Jet	vn. State)	n Rd, W	aldof, MD
	e Hospital or Attending Physician: 24 hours atter death. 6 Funeral Director: After this certific letely filled in by the funeral director,	edical (29a. Certifier (Check only one)	1☐ Certifying 2☐ Medicel Ex	aminer: On the	he best of my	knowledge, dea	ath occurred at the time	ne, date and place, a pinion, death occurr	and due to the ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the He within 24 To the Fu completel	Med	29b. Signature and	title of certifier	and m			29c. Licens				e signed (Month	
) sou	Marz	enru	2	MO	OCME			Janu	ary 8 2	2004
(00		30. Name and addre					a, Print)	on Street	+feq ·	imore	Marrol	and 21201
	Sta	to.	31. Date filed (Mont	CL L Z	emne 32	S I I II	Signature .		am street	, Dart	TINT	, intry	21201
	Registr			JAN 0 9	2004	Aloeus	Signature	good					

			For State Registrer	State	of Maryla		artmen rtificat			and M	ental Hy	/giene		+ 01	556
	Division		1. Decedent's Name (First, Middle	, Last)							2. Date of Do	eath Da	ly Year	3. Time o	of Death
	Physici /Medi		Shirley Woodfo								Januar		-	1430	М
4	Examir	ner	4a. Facility Name (If not institution				4b. City,	Town, or	Location of	of Death		40	. County of De	ath	
			Montgomery Gen			toothint to	01ne		If I Indon	04 Hea T			ontgome		
	Funeral Director		5. Social Security Number 235-60-5881	6. Sex 1 ☐ M 2 🛣 F	7. Age (in yrs	. last birthday) Yrs.	Months		Hours 1	Min.	8. Date of Bi (Month, Di	rth <i>ay, Year,</i>	9. Bi	rthplace (State country)	
		1	Usual Residence of Decedent		00						Dec. 2	<u> </u>	1935 We	st Virg	inia_
	nylan how		10a. State 10b. County		10c. C	ity, Town or Lo	ocation							10d. Inside C	City Limits
	e Ma	당	Maryland Montg	omery	01:	ney	_							1 X Yes	2 □ No
	計 20.28	Dire	10e. Street and Number				10f. Zip	Code				10g. Ci	tizen of What C	ountry?	
	ath w	Funeral Directo	3801 Brooke Me					332_					SA		
	er de Items	nue.	11. Marital Status	Armed F		J.S. 13.	Was Deced If Yes, spec	dent of His cify Cubar	spanic Orig n, Mexican	gin? (Spec , Puerto R	cify Yes or No lican, etc.)	0-	14. Race - Am Black, Wh		
36	irs aft	by	1 ☐ Never Married 2 ☐ XMarr 3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or [2∭No ive ⊃ates:		1 ☐ Yes	2 ∑ No	Specify:				Specify: Wh:	ite	
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-1 show raumatic avent, the Macical Exambler must be positived at	ted	15. Decedent	's Education	1/1-	16a. Dece	dent's Usua	al Occupa	tion			16b. K	ind of Business	/Industry	
215	hin 7	pie	(Specify only highes Elementary/Secondary (0-12)		1-4or 5+)	(Give	kind of wo DO NOT u	rk done d se retired,	uring most	of workin	g				
21	ad wil	Completed	12			Homen	naker						Own Home	2	
pu	be filk tal Hy d oth	Be	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middle	, Maider	Sumame)		
З	ould Men Marke Marke	ပ	Rodney Felton								. Wood				
Maryland	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: If item 27 Is marked other than "natural", or Items 23s or 28s-1 show any njury or other traumatic avent, the Madical Examiner must be profilled at one.		19a. Informant's Name/Relationsl Joseph A. Hand		- Spoug								or Town, State,	Zip Code)	
	1 and Healtl ern 2		20a. Method of Disposition	1ey, 51		Place of Dispo		and the same	adow	Lane			ocation - City or	Town State	
Baltimore,	ages nt of :: If it	1	1 Burial 2 Cremation		State	cemetery, crei	natory or o	ther place	· .						
臣	rtant riun		' 4 □ Donation 5 □ Other (Sp. 21. Signature of Furreral Service I		LO								imore, Funeral		
Ba	permit. Departr Imports any inj	1	1/ Laine		TITIE								runera. r Spri:		20904
			23a. Part1. Enter the disease, or	complications that	caused the dea								- DPIII	Approxima	te
	Physician		Immediate Cause (Final	only one cause on	each line. 1aphhyla									Interval Be Onset and 1 hou	Death
	/Medical		disease or condition resulting in death)	a	(or as a conse									1 1100	
П	Examiner		Consensation that are added		spirato		.lure							l hou	r
	D #	ne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec										
	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	arian (3 mon	ths
8760,	ate be executed hysician and the burial-transit		resulting in death) Last		oras a consecution of a									***0.0	rc
87	h y	Physician/Medical		d	TGTOME									yea	
9 x	eath certific attending pl	/We	IF FEMALE:	23c. If yes, ou	tcome of pregn	ancy									
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live I	ointh 2 ☐ Fete	eldeath 3□	Ectopic produced of the control of t						23d. Date of de Month	Day	Year
P.O.	that the de led by the a detached t	ysi	1 Yes 2 No 9 Unknown	9□ Unkn			3 O 1110. (Op.	Joney							
	res that igned b be deta	by PI	Part II. Other significant condition	ns contributing to d	eath but not res	sulting in the u	nderlying ca	ause givei	n in Part I.		23e. Did t	obacco u	se contribute to	the cause of	death?
rds	w require: been sig should b	d be	Diabetes								10	Yes 2	□No 3□P	obably 4 🗴	Unknown
ပ္သ	aw requ s been 2 shouk	piet	Breast Cancer								24a. Was		24b. Were at	utopsy findings	available
of Vital Records,	The lay cate has page 2	Completed									autor perfo 1 ☐ Yes	rmed?		completion of 2 No	cause or
ital	10	Be C	25. Was case referred to medical examiner?		171-2				26. Place	of Death /	Check only o		1 🗆 103	25110	
5	tending Physician: leath. tor: After this certifica the funeral director, I	ပ္	1 ☐ Yes 21 No		·	ER/Outpatien	t 3 🗆 DO	Other	4 □ Nur	sing Home	e 5 🗌 Resid	dence	6 □Other (Spe	cify)	7,4-7
ū			27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury		8c. Injury Work	at ?	28	d. Describe t	how injur	y occurred		
sio	Attending r death. sctor: After	cati	2 Accident investig 3 Suicide 6 Could n	ot he			М		es 2 □N						
Division	i die	Certification:	4 Homicide determi	ned 28e. Place	e of Injury - At h ing, etc. <i>(Speci</i>		eet, factory	, office		28	f. Location (5 City or Tox		d Number or Ri)	ıral Route Nur	nber,
_	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by		29a. Certifier 1 XCertifying	Physicien: To the	hast of multi-	nwledge doeth	0000000	at the time	data 1	I place =	d due to the			atata d	
	24 h	edical	(Check only 2 Medical E	exeminer: On the b	asis of examina	ation and/or inv	estigation,	in my opi	nion, death	n occurred	at the time,	date and	and manner as place, and due	to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier				29c	. License	number			29d. Dat	e signed (Mont	h, Day, Year)	
	1		POR					MD60	335			Janıı	ary 5,	2004	
	12		30. Name and address of person v	who completed caus	se of death (Iter	n 23a) (Type,							-, -,		
			Paul Bannen, M	.D. 1811	Prince	Philli	p Dr.	#32	7 01n	ey, 1	MD 208.	52			
	Sta		31. Date filed (Month, Day, Year)		legistrar's Signa	ature 4	A.n.	der.	,						
	Registr	ar	IAN 092	1104	per	100	JEST SON	STATE OF THE PARTY							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth

Physician
/Medical
Examiner

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Meryland Depentment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

Examiner physician and s the buriel-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, for use es funerai efter death.

0

30. Name end eddress of person who completed cause

JAN 0 7 2004

-GOV2

31. Date filed (Month, Day, Year

1. Decedent's Name (First, Middle, Last) Dey EDITH HELFER JANUARY 1, 2004 11:45 PM 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death HEBREW HOME OF GREATER WASHINGTON MONTGOMERY ROCKVILLE 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral Days Hours 1 ☐ M 2 🕱 F Yrs 091-14-8781 104 12/23/1899 RUSSIA Usuel Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits MARYLAND MONTGOMERY **Funeral Director** ROCKVILLE 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10c. Citizen of What Country? 6036 LOGANWOOD DRIVE 20852 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: WHITE Be Completed by Specify: 3 Nidowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 CLERK BAKERY 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) JOSEPH GOLDSTEIN LENA FINKELSON 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) HARRY PITT-SON 6036 LOGANWOOD DRIVE, ROCKVILLE, MARYLAND 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 01/04/ 1 Burial 2 ☐ Cremation 3 反 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH EL CEMETERY 2004 PARAMUS, NEW JERSEY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 er or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Physician MYOCARDIAL INFARCTION Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown þ Completed 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 2 1No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Tol Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Truising Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28e. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Watural within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

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deeth (Item 23e) (Type, Print)

Degistrar's Signature

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		1 - For State Registrar	State of M	Marylan				ealth a	and M		Reg. No.	200	ļ.	-	558
Physic	ian	Decedent's Name (First, Middle, La.	st)							2. Date of Dea Month Januar	Day	200 ^{Ye}	ar	3. Time o	of Death A M
/Med	ical	Linda Lo Hsieh 4a. Facility Name (If not institution, give	e street and number	r)		4b City	Town or	Location of	of Death	Januar	-	County of D	eath	9.33) A "
Exami	ner	17716 New Hampsh:		7		Asht						ontgom			
Funeral Director		5. Social Security Number 6. S		ige (In yrs. 85	last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da Feb. 15	h v, Year)	9. 918 Ch	Birthpla Country 1na	ce (State y)	or Foreign
nyland show		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							100		City Limits
h the Ma or 28a-f	Funeral Director	Maryland Montgome 10e. Street and Number	ery	As	hton	10f. Z	p Code				10g. Citi	zen of What	Countr	Λ	
th wit	a D	17716 New Hampshi	re Ave.			2	20861				US	SA			
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or itama 23a or 28a-f show aumatic event, tra Medical Examinar must be notified at	b	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 Yes 2X If Yes, Give Year or Dates	;?] No	-	Was Dece If Yes, spo 1 Yes		ispanic Ori in, Mexican Specity:	gin? (Spa n, Puerto	ecify Yes or No- Rican, etc.)	-	14. Race - A Black, W Specify:	/hite, et		
d within 72 hours at giene.	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-40	r 5+)		kind of w DO NOT i	ial Occupa ork done o use retired	ation during mos	t of work	ing		nd of Busine	ss/Indu	stry	
ed wi yglen yglen t, t.	S		4 Yrs.		Arti	st		40.14-4-		(C)	Ar				
ed la b	To Be	17. Father's Name (First, Middle, Last, S.H. Lo						F.C.	. Cha					·····	
C, MICH 1 and 2 sho Health and 1em 27 is m		19a. Informant's Name/Relationship (Bernardine Bowers		er						al Route Numbe 7e. Asht				Code)	
permit. Pages 1 and 2 should Department of Haalth and Mer Important: If Item 27 is marke any injury or other traumatic once.)	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specif]Removal from Stat	_ 0	Place of Dispo cometery, cres don Pa	natory or rk C:	_{other plac} cemat	ory (01/09	9/2004	Ва	cation - City ltimor	e,	MD	
permit. Departm importal any inju		21. Signature of Juneral Service Licer		h	22	2. Name a	nd Addres	s of Facilit	yHine nire	es-Rinal Ave. Si	ldi Llve:	Funera r Spri	1 H	ome MD 2	20904
Physician		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each	line.	h. Do not ent			g, such as	cardiac (or respiratory ar	rest,			Approxima nterval Be Onset and Year	Death
/Medical Examiner		resulting in death) Sequentially list conditions, fam, learning to immediate cause. Enter Underlying	b. Due to (or a												
icate be executed physician and the burial-transit	Ilcai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	is a conseq	uence of):										
death certifi e attending of for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Feta	Ideath 3	⊒Ectopic] Other (s	oregnancy pecify)					23d. Date of Month			Year
us, r., juires that n signed b	þ	Part II. Other significant conditions of Hypertension	contributing to death	but not res	sulting in the u	nderlying	cause givi	en in Part I				se contribute □No 3□			death?]Unknown
or Attending Physician: The law requires that the affect death. Director: After this certificate has been signed by the in by the tuneral director, page 2 should be detached.	Completed	Atrial Fibrill	ation				. <u>-</u>			24a. Was autop perfo		24b. Were prior death	to comp	y findings pletion of	s available cause of
ysician: The sectificate director, pag	Be	25. Was case referred to medical examiner?								n (Check only o	ne)				
hysic this ce al dire	10	1 Yes 2 No	Hospital:		ER/Outpatier					me 5 Resid			Specify)		
Attending Physician: r death. ector: After this certifics by the funeral director;	atlon:	27. Manner of Death 1 Anatural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be		njury Day Year)	28b. Time o Injury	М	28c. Injun Worl	yat k? Yes 2□	No	28d. Describe t					
To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	200. Place of t	njury - At h etc. <i>(Specil</i>	ome, farm, sti fy)	reet, facto	ry, office			28f. Location (5 City or Tox	Street an vn, State	d Number or)	Rural I	Route Nur	mber,
To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysician: To the bearing: On the basis and manner	of examina	owledge, deat ation and/or in	h occurre vestigatio	d at the tin n, in my o	ne, date an pinion, dea	id place, ith occuri	and due to the red at the time,	cause(s) date and	and manner place, and o	as stat due to th	ed. he cause((s)
To th To th	×	29b. Signature and title of certifier				25	c. Licens					e signed (Ma			
20		30. Name and address of person who	My on	MO f death (Iter	n 23a) (Type,	Print)		124				nuary		2004	
		Dr. Dennis M. Ha	nnon, M.D	. 290	1 01ne	y-Sai	ndy S	pring	g Rd.	Olney,	MD	20832			
S: Regis	tate trar	31. Date filed (Month, Day, Year)	114 32. Hagis	strar's Signa	G	de	ack								

			1 - For State Registrar	State of	of Maryl		artment of rtificate of		and Mental H	ygiene 2 (104	0155
			1. Decedent's Name (First, Midd	le, Last)				_	2. Date of D	eath		3. Time of Death
	Physici /Medi		PRIS	CILLA	Ε.	HYLE			JAN.	5, 2	Year 2004	5:51 p ^M
	Examir		4a. Facility Name (If not institutio	n, give street and nu	ımber)		4b. City, Town,	or Location of		4c. County		3.31 p
			LAUREL REGI	ONAL HOSP	TTAL.			LAUREL		PRTN	CE GI	EORGES
	Funeral		5. Social Security Number	6. Sex		yrs. last birthday)	If Under 1 Year	r If Under	24 Hrs. 8. Date of B	irth	9. Birthp	lace (State or Foreign
E	Director		579-22-7801	1 □ M 2 □ x F	85	Yrs.	Months Days	Hours	Min. (Month, D	15,1918	WAS	SH. D.C.
Б			Usual Residence of Decedent		1.0							
aryla	you a	<u>_</u>	10a. State 10b. County		100.	. City, Town or Lo	ocation				1	Od. Inside City Limits
9E	- Ba-	cto		E GEORGES			HYATTS	VILLE				1 X Yes 2 □ No
1215-0036 within 72 hours after death with the Maryland	or 2	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of \	What Coun	ntry?
ath w	238	rai	2250 LEWI	SDALE DR.				20783		υ	.S.A.	
ar de	E E	rue	11. Marital Status	12. Was Dec Armed Fo	orces?	n U.S. 13.	Was Decedent of	Hispanic Original	gin? (Specify Yes or N , Puerto Rican, etc.)		e - Americ	
36 s affe	P E	γFi	1 Never Married 2 Mar	If Yes, Gi	ve -	1	1 ☐ Yes 2 🕱 No		•	Specify		0.0.
00 iii	ural'	q p	3 Widowed 4 Divorced		ates:					- Opecing	WE	IITE
21215-0036 ad within 72 hours aff	"nat	ete	15. Deceder (Specify only highe	it's Education st grade completed)		(Give	dent's Usual Occu kind of work done	during most	of working	16b. Kind of B	usiness/Inc	dustry
基	than .	m du	Elementary/Secondary (0-12)	College (1-4or 5+)	iire.	DO NOT use retire					
N Del	Hygie ther I	ပိ	12 17. Father's Name (First, Middle,	(act)			HOMEM		d- No		HOME	
Maryland d 2 should be file	ever of	Be		,				18. Mothe	r's Name (First, Middle	e, Maiden Suman	10)	
S on	nark natic	5	EDWARD		OST				MONA		GHES	
2 st	raun		19a. Informant's Name/Relations	1 1 77	_				r or Rural Route Numb			
and and	m 27		CHARLES J. H	YLE/HUSBAI		2250		ALE DR	., HYATTSV			
0 8	2 = 3		20a. Method of Disposition 1 ☐ Burial 2 ত Cremation	3 □Removal from		 Place of Dispo cemetery, crer 	sition (Name of natory or other pla	ice)	Date	20c. Location -	City or To	wn, State
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any piritory goother traumatic event, the Modical Examinat must be notified at once.		- 8	'4 □Donation 5 □ Other (S						1-6-2004	RIVER	DALE,	MD.
<u>a</u>	pour pour ny in		21. Signature of Funeral Service	Licensee	0	C1	Name and Addr	ess of Facility	L HOME & C	₽₽₩₩₽₽₽ ₽	IIM D	A
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ficate be executed represented physician and represented sthe burial-transit	Medical aminer	il Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease of Figure 1) that initiated events resulting in death) Last	b. Due to	(or as a cons	sequence of):						Interval Between Onset and Death
O. Box 6	by the attending ached for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		ointh 2 F	etal death 3	Ectopic pregnanc Other (specify) _	у		23d. Dat Mor	e of deliver	ry Day Year
Hecords, P. The law requires that	igned be det	by P	Part II. Other significant condition	ons contributing to de	eath but not	resulting in the ur	nderlying cause gr	ven in Part I.	23e. Did	tobacco use contr	ibute to the	e cause of death?
Hecords, he law requires t	been sig should b	edl	DUODENAL UL	CER, HYPER	RTENSI	ON			10	Yes 2 □ No	3 🗌 Proba	ably 4 XUnknown
O ≗	as bee 2 sho	Completed	HIATAL HERN	ΓΔ					24a. Was	an 24h V	Vere auton	sy findings available
T P	£ 9	mc							— auto	psy p prmed? d	rior to com eath?	pletion of cause of
	certificate rector, pag	ပိ	ESOPHAGITIS 25. Was case referred to medical						1 ☐ Yes	2(X No 1	☐ Yes 2	2 🗆 No
	r this certifica	Ö	examiner? 1 Yes 2 X No	Hospital:		O con	Otto		of Death (Check only			
	r this	H	27. Manner of Death	28a. Date	of Injury	ER/Outpatien 28b. Time of	28c. Inju	4 Nur	sing Home 5 Resi	dence 6 Other)
	After	ţ	1 Matural 5 ☐ Pendin 2 ☐ Accident investig	g (Mont	th, Day Year,) Injury	Wo	rk? Yes 2⊟N		now injury occurre	ou .	
UIVISION I or Attending	Dire	Certification:	3 Suicide 6 Could i	not be 28e. Place	of Injury - Al	l home, farm, stre ecify)	-	700 20.0		Street and Numbe wn, State)	er or Rural	Route Number,
Hospite 4 bours	Funerel ely filled	edical Ce	29a. Certifier (Check only one) 1 Certifyin 2 Medical	exemmet: Ou fue by	best of my kasis of exam	knowledge, death ination and/or inv	occurred at the tilestigation, in my o	me, date and opinion, death	place, and due to the noccurred at the time,	cause(s) and mar date and place, a	nner as sta	ited. the cause(s)
To th	To the complet	Me	29b. Signature and title of certifier			•	29c. Licens	se number		29d. Date signed	(Month, D	ay, Year)
			1 /8 Acul	OMD	Alle	nding	-	160E00		7437	F .	2007
20	,	-	30. Name and address of person	who completed caus	e of death (II	tem 23a) (Type I		62580		JAN.	5,	2004
			PARMJIT S.				-iv	C DD	#12 DT ADT	MCDITTO	MD 4	20710
Y	Sta	e l	31. Date filed (Month, Day, Year)		M.D. egistrar's Sig				#13, BLADE	ENDDUKG,	ш у. .	20/10
66	Registr			2004	Russia		home	r in				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 16, Month JANUARY **Physician** 2004 10:50 a.M Rosella Hiser Esther /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4h City, Town, or Location of Death **Examiner** ALLEGANY CUMBERLAND Memorial Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, NOV 1, Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ XF 213-18-2818 84 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene Important: If item 27 is marked other than *natural', or iteme 23s or 28s-f show amportant: If item 27 is marked other than *natural', or iteme 23s or 28s-f show amp injury or other traumatic event. If a Medical Exp. in at trues for collibrations. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Allegany MD Cumberland 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 701 Furnace Street 21502 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: White þ 3 ☐ Widowed 4 No Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Keyser Refactory Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Samuel Harrison Lewis Bessie (DuMar) Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) WV 26767 Charlotte Felton daughter 11 Laurel Drive Wiley Ford 20a. Method of Disposition

1 Burial 2 Aremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, PA 20c. Location - City or Town, State 1/19/2004 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee rames 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ASPIRATION PNEUMONIA 3 WEEKS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably Unknown Be Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performa 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 20 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred After Injury Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) January 19 , 2004 D36766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vik Poonai M.D. 924 Seton Drive Cumberland, Maryland 21502

Date filed (Month, Day, Year)

JAN 2 2 2004

Registar's Signature 31. Date filed (Month, Day, Year) JAN 2 State Registrar

				State of N	Maryland / De			•	•	ol olmal
			1 - For State Registrar			ertificate of			g. No.	04 01561
	Physici /Medi		1. Decedent's Name (First, Middle Quentin	P. (Last)	Iv	ngram		2. Date of Death Month Januar	Day	3. Time of Death 2154 M
	Examir		4e. Fecility Name (If not institution		r)	4b. City, Town,	or Location of Death		4c. County of	Deeth
	Funeral		Johns Hopk 5. Social Security Number	6. Sex 7.	Age (In yrs. last birthda	Baltin av) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Balti	MOVE CITY
	Director		218-41-9690 Usuel Residence of Decedent	¼ M 2□F	9 Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Day, July 17,		9. Birthplecs (State or Foreign Country) Maryland
	arylan show	۰	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	he Millie	Funeral Director	Maryland Freder	ick	Mount A				- 611	1 ☐ Yes 🌠 No
	3a or	I Dir	14120 Peddicord	l Pond		10f. Zip Code	771	10	g. Citizen of Wh	•
	death	nera	11. Marital Status	12. Was Deceder	nt Ever in U.S. 1		Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No-	14. Race -	- American Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumetic avant, the Medical Exercitivating as revilined at	þ	1 X Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	No	1 ☐ Yes, specify Cut		Hican, etc.)		White, etc. Biracial
5-0	natu	Completed	15. Deceden (Specify only highes	's Education it grade completed)	(G:	cedent's Usual Occu	during most of work	ing	6b. Kind of Busi	
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	illed Hygid other	Be Co	17. Father's Name (First, Middle,	Last)		Ludent	18. Mother's Name	e (First, Middle, Me		
<u>la</u> r	should be nd Mental marked o umatic ava	To B	John Otha 1	ngram			Janet L	ee Kate	s	
Maryland	2 sho and ls mu		19a. Informant's Name/Relations	nip (Type, Print)	19b. Ma	ailing Address (Stree	t and Number or Rura	al Route Number,	City or Town, St	ate, Zip Code)
	f Health Item 27 other tr		Janet K. Ingran	<u>- Mother</u>	20b Place of Dis	20 Peddica	ord Road,			land 21771
Baltimore,	ages int of t: # lt		1X Burial 2 Cremation			sposition (Name of trematory or other plants				
Ħ	permit. Page Department o Important: If any injury or once.		* 4 □ Dopation 5 □ Other (S) 21. Signature of Futueral Services		Restna	22. Name and Addr	Gardens 1/	8/04 F	rederic	k, Maryland
Ä	Dep Imp		tover L	- Willis	im !	Olin L. Mo	lesworth e Road.	P.A., Fui	neral Ho	ome and 20872-0117
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	ed the death. Do not e	enter the mode of dy	ing, such as cardiac	or respiratory arres	t,	Approximate Interval Between
	Physician	10	Immediate Cause (Final disease or condition		onary L	remove	hage			Onset and Death
*	/Medical Examiner		resulting in death)	Due to (or a	is a consequence of);		Ö	1 100		il
	w ()-	er	Sequentially list conditions, if any, leading to immediate	b. Systel	MIC QO	enovivu	is infec	Ton		Zmonths
	executed and al-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. bone Due to (or a	malvool	w trav	nsplanto	ation		3 months
68760	icate be e physiciar s the buri	cal		(a acute	myeloi	d lenk	emia			6 months
Box (The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No		2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	ey		23d. Date of	
P.O.	that the di ed by the detached	hys	9 Unknown	9□ Unknown						
	w requires that been signed should be de	by	Part II. Other significant condition acute renal	failure,	2	underlying cause grantes him	ven in Part I.			ute to the cause of death?
Vital Records,	The law recate has be page 2 sho	Completed	bleeding, r	espiraton	y failu	re, hyp	otension	performe	prio dea	re autopsy findings available or to completion of cause of th? Yes 25 No
/ita	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?				26. Place of Death		3.40	213110
of \	this al du	P	1 Yes 2 No	Hospital: 1 Inpat		Ient 3 DUA		me 5 Residence		(Specify)
	ding I h. After funer	tlon	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig		jury 28b. Time lay Year) Injury	y Wo	ryat rk?]Yes 2 □ No	28d. Describe how	injury occurred	
Division	De Se	flca	3 ☐ Suicide 6 ☐ Could r	ot be 28e. Place of Ir	njury - At home, farm,			28f. Location (Stree	et and Number	or Rural Route Number,
ă	Hospital or Attanding 14 hours after death. Funeral Director: After tely filled in by the funer	Certification;	4 Nomicide	building, e	etc. (Specify)			City or Town,	State)	
	To the Hospital or Attuwithin 24 hours after de To the Funeral Directo completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifyin 2 Medicel I	g Physician: To the bes Examiner: On the basis and manner s	or examination and/or	ath occurred at the ti investigation, in my o	me, date and place, a opinion, death occurre	and due to the caused at the time, date	se(s) and manne and place, and	er as stated. I due to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	2		29c. Licens	se number	29d	. Date signed (A	Month, Dey, Year)
			177		10	RES	-000	Jo	inuan	42,2004
	7		30. Name and address of person			e, Print)	Le C.t.	Ralhin	100 M	42,2004
	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	600 trag's Signature	N. WOI	10 71.	verilla	iore, h	IVUCST
	Registr		JAN	- 7 ZUU4 b	Depera	D 1	200 Kg/			

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item # 4pr Cecil Co. 1- State Registral/8/04 rjw Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Bernice A 11:50 A nole base m 2004 /Medical 3875 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Telegraph Road ElKton If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 2 TF 82 Days Hours BUSTON 019-26-6597 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r than "natural", or items 23a or 28a-f shov the Medical Experient must be notified at Florida Horbo 1 Yes 2 □ No Dadz **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U. S.A. 10275 33/3 AUC. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specity: White, Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ 3 ☐ Widowed 4 M Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Design. Elementary/Secondary (0-12) Designer Intarion other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Imporbant: if itam 27 is markad oth any injury or other traumatic event 2008. pple becom Rose Jecob 19a. Informant's Name/Relationship (Tyle, rint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cutler Rdy ElKton MD 21921 Jane Telegra 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 4,2004 Shown Mean. Park 22. Name and Address of Facility
Schoonby Mem
5-19 Philade ph 21. Signature of Funeral Service Licenses Che Makies 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heap railwrs. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASCVD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Lusseas or injury that initiated events Due to (or as a consequence of) Examiner signed by the attending physician and d be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 2/K) No 1 ☐ Yes spital or Attanding Physician: Ti hours after death. neral Director: After this certificate y filled in by the funeral director, pa 25. Was case referred to medical 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Jan 2. 2004 a

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

31. Date filed (Month, Day, Year) JAN 0 8 2004

Union Hospital

32. Registrar's Signatur

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** January 2, 2004 6:00am M Maxene E. Jubien /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Wilson Health Care Center Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🖾 F Yrs. 1925 Ohio Director 273-22**-**7395 78 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Show r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Gaithersburg Maryland | Montgomery Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 931 Wild Forest Drive 20879 United States death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify þ 3 XWidowed 4 ☐ Divorced WWII White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 sincur. —
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "nr
any injury or other traumatic event, Ira Medi Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Aeronautics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lela Perkins Arlo Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48 Flounder Drive, Sebring Florida 33875 Donna Hedges (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Quantico Nat'l Cem. `4 ☐ Donation 5 ☐ Other (Specify) 1/7/2004 Quantico, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 Link Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute myorardial infanction Minules **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): physician a the burial-1 Box 68760 by Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ó 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I., 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Chroniopstructure pulmos 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed numed of chimicales 1 Yes 2 No 2 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☑ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA this 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death
Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) > 4- Robert Bersel bardes 204115 tanccary 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 Russell Avenue, Gaithersburg, MD 20877 H. Robert Birschbach, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene 2000For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JAN 0.5 0.5 2004 **Physician** JOSEPH CARLTON JONES 1:20 A M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1⊠M 2□ F Director 51 May 26, 1952 Florida 141-46-0661 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28s-f show many liviny to other traumatic event, the Medical Exercitive Installe notified at once. 1 Yes 2 No Director Silver Spring Montgomery Maryland | 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 USA 2019 Hickory Hill Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 No 1 ☐ Never Married 2 AMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1981-2003 1 ☐ Yes 2 🖾 No Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Human Resources Manager 5+ U.S. Army 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Willie Jones Jewerl Mann ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) LaSonia F. Jones / Wife 2019 Hickory Hill Lane, Silver Spring, MD 20906 20b. Place of Disposition (Name of competery, crematory or other place)
Arlington National Date 20c. Location - City or Town, Stete 20a Method of Disposition January 22 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington, VA 2004 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc 21. Signature of Funeral Service Licensee 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition METASTATIC COLORECTAL CANCER **Physician** resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 DEctopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 1□ Yes 2□No certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Anpatient 2 ER/Outpatient 3 DOA Other: 1 Yes 2 XNo 4 Nursing Home 5 Residence 6 □Other (Specify) Medical Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident in by the Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide within 24 hours after To the Hospital Pelli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 06 JAN 2004 0101234404 (VA) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 TODD D. GLEESON LT MC USNR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 09 2004 bouke Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registra Certificate of Death Rag. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Ellwood Ray Kirby 11:45 AM January 06, 2004 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner **Allegany** 16808 Dutch Hollow Road Mount Savage If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 ☐ F Yrs. 217-14-4287 81 Director 05-Sep-1922 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or Items 23s or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Allegany Director Maryland Mount Savage 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16808 Dutch Hollow Road 21545-U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: WW 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after bepartment of Health and Mental Hygiene. Important: if item 27 is marked other than "neturet," or Item any injury or other treumatic event, the Medical Ferral Once. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ል 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) custodian board of education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Harvey Kirby Bertha Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16808 Dutch Hollow Road Emma Kirby Mount Savage 21545-Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Saint Patrick's Cemetery 09-Jan-2004 Mt. Savage Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) refasta Priysician moulta /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed led by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Dunknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2□ No 1 ☐ Yes 2 No 1 Tyes To the Hospitel or Attending Physicien: within 24 hours after death.
To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient Certification; To 1 Tes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation s after de-rai Diractor: Afte М 1 Tes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🌠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies DOOC0478 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cumberland, MD 21502 Suite 102 625 Kent Ave. Ataq Ahmad 31. Date fled (Month, Day, Year) 32 Registrar's Signature State JAN 0 7 2004 Registrar

			1 - For State Registrar	State of Marylan		rtment of H			giene Reg. No. 200	4 01566
			Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ath	3. Time of Death
	Physici /Medic		Okey	Wesley		Kenney		JANUARY	,	00:05 a. M
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Dea	ith	4c. County of De	ath
			Memorial Hospital			CUMBERLA			ALLEGANY	
2	Funeral		5. Sociat Security Number 6. Sex	7. Age (In yrs. 79	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. (Month, Day	h 9. B	rthplace (State or Foreign Country)
	Director		219-14-5559 Usuat Residence of Decedent	19				04/15/1	1924 We	st Virginia
	yland		10a. State 10b. County	10c. Cit	y, Town or Loc	cation				10d. Inside City Limits
	a-fal	to	WV Minera	1	Ridgel	ey				1 ☐ Yes 2 💆 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?
	filed within 72 hours after death with the Maryland Hygiene. The than "naturel", or tlems 23a or 28a-f ahow ant, the Madical Examina must be neitlied at		Route #3 01d Furn			267			USA	2.2
	er de	Funeral		2. Was Decedent Ever in U Armed Forces?	.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh	
36	irs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1X Yes 2 No 194 If Yes, Give 194 Year or Dates: 104		☐ Yes 21 No	Specify:		Specify:	
ŏ	2 hou	ted	15. Decedent's Educ	ation 174	16a. Deced	ent's Usual Occupa	ation		16b. Kind of Busines	White s/Industry
212	hin 7.	Completed	(Specify only highest grade Etementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give I life. D	kind of work done d O NOT use retired,	furing most of we)	orking		
21	ad wit glend er thu	Con	10		C1	erk			Railroa	d
<u>n</u>	d oth	Be	17. Father's Name (First, Middle, Last)	s Golden	Van			ime (First, Middle,		
<u> </u>	should be nd Mental marked o	ဥ	Okey Thoma		Ken		Daisy		Wagner	
<u>a</u>	0 0 2 0	7	19a. Informant's Name/Relationship (Typ					y Ford, V	r, City or Town, State, WV 26767	ZIP Code)
a Č	1 and Health Iem 27 other to		D. Karen Comer / 20a. Method of Disposition	20b. F	Place of Dispos	ition (Name of		Date	20c. Location - City o	r Town, State
<u>و</u>	Peges nent of int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emovai from State		atory or other place	1	14/2004	Cumber1a:	nd MD
Baltimore, Maryland 21215-0036	permit. F Departmo Importar any injur	- 24	21. Signature of Furral Service License					the second second second		1 Home, P.A.
ñ	Per	77	Labort C. C	Lelens					umberland,	•
executed // Medical Examiner ial-transit			23a. Par1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, isading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e cause on each line. Due to (or as a conseq	uence of):	TIVE	HE	ART,	FAILUR	Approximate Interval Between Onset and Death
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\frac{1}{2}	Attending Physician: r death. ector: After this certific. by the funeral director.	Be c	25. Was case referred to medical examiner?	ospitat:		aci pos Othe	100	ath (Check only or		
ō	Phys r this eral dii	5.	1 Yes 2 No	1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of	3LI DOA	4 🗀 Rursing		ence 6 Other (Spe ow injury occurred	ecify)
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Division of	ospital or Attendi hours after death, uneral Director: A ly filled in by the fi	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	et, factory, office		28f. Location (S. City or Town	treet and Number or F n, State)	lural Route Number,
	T 4 IT 0	edicai (29a. Certifier 12 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kno ler: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the tim estigation, in my op	e, date and plac inion, death occ	e, and due to the c urred at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
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d	n 2 0		30. Name and address of person who con)(1 PT/T : : : -	01500	
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			. For	State of M	laryland	/ Depa	artment o	of He	alth a	ind Me	ntal Hy	giene	2001	0156	7
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yla Yla	Men Marke natic	၉	Ernest A. Kidwe			10h Mailir	ag Address (S				Coste		Town, State, 2	Zin Code)	
Nai	thand thand 17 Is n treun	1111	19a. Informant's Name/Relations Linda Kidwell/W											and 21783	
re,	f Heal item (l	20a. Method of Disposition		20b. Pla		sition (Name matory or othe			Date			ation - City or		_
imo	nent o		XX Burial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (S		e 1					an. 9,	2004	Frede	erick,M	laryland	
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<u>و</u> م	s man n ned by e detar	by Ph	Part II. Other significant conditi	ons contributing to death	but not resul	lting in the u	nderlying cau	se given	in Part I.		23e. Did to	obacco us	se contribute to	the cause of death?	
rds	w requires been sign should be										101	Yes 2□	2 № 3 □ Pr	obably 4 □Unknown	1
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/ita	certificate rector, pag	Be	25. Was case referred to medica examiner?	Hospital:				1			Check only o	•			
of \	S S	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Ir		P/Outpatier 28b. Time o	nt 3 DOA	Other:	4 🗀 140	rsing Home 280	5 AResid	dence 6	Other (Spe	cify)	-
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3	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier 1 ☐ Certifyi (Check only 2 ☐ Medical one)	ng Physician: To the be Examiner: On the basis and manner	of examinati	viedge, deat ion and/or in	n occurred at ivestigation, in	my opir	nion, dear	th occurred	at the time,	date and	place, and due	to the cause(s)	_
F	To the within 2 To the complete	Me	29b. Signature and title of certific	er C				License r		1			signed (Mont	-	
	7		>devad	W, Dif	40 II	772) <u>/</u>	0 -	106	-	- 1	U d	ce R.	, 2004	
			30. Name and address of person	wno completed cause o	r death (Item	≥3a) (Type, >	Print) 19	106	1 or	cha	d t	enso	ce R.	<u> </u>	
	Sta	ate	31. Date filed (Month, Day, Year		strant Signat	ure	4	1	Ja.	5 1000	d t.	(1)	2176		
	Regist	rar	JAN	I - 7 2004 ►	June		1	140	ane,	4					

State of Maryland / Department of Health and Mental Hygiene 🤈 State Registra MEND#7perFH1/7/04, BMW, McCo Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** JANUARY 4, ELAINE 2004 Α. 9:33 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex Birthplece (State or Foreign Country) Funeral 1□ M 2□F Director 213-44-7484 1945 WASHINGTON, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show 1 Yes 2 No MARYLAND MONTGOMERY SILVER SPRING Direct the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? s 23a or 603 CHICHESTER LANE 20904 UNITED STATES death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 🛣 Marned Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 📉 No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: naturel WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Une Mis Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 Is marked other than uryer other traumatic event, Ins. HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SUSSMAN ABRAHAM ٩ MARY **FUTTERMAN** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KENNETH D. KAPLAN, HUSBAND 603 CHICHESTER LANE, SILVER SPRING, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If its any injuryer of once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) NATIONAL CREMATORY 1/7/04 FALLS CHURCH, VA permit. 21. Signature of Funeral Service DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the stath. Do not enter the mode of dying, such its cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician marthe /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, backing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy for Month Day Year 5 Other (specify) P.O. I detached 9 Unknown 9 Unknowń Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2**)** No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 Yes 2 X No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 XNatural 5 Pendina death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the 1 within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital pelli Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and ittle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who controlled cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 7 2004 Registrar

			1 - For State Registrar	State of Marylan	•		of Health of Deatl		_	giene Reg. No.	2001	01569
Į			Decedent's Name (First, Middle, Last)						2. Date of De	aath		3. Time of Death
	Physici		NORRIS CALV	IN KILMON	. SR.				Jan.	13^{Day}	200 ^{Year}	11:11 PM
	/Medic Examin		4a. Fecility Name (If not institution, give st Civista Medical	reet and number)		, ,	own, or Location			ŧ	County of Dea	
	Funeral Director		5. Social Security Number 228 − 18 − 5211	7. Age (In yrs. 88	last birthday) Yrs.	If Under 1 Months [Year If Under Days Hours	Min.	8. Date of Bi (Month, Da	ay, Year)	C	thplace (State or Foreign buntry) RGINIA
,	pu		Usuel Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f ehow roust be notified at	ច	MARYLAND CHARL		WALD							1 ☐ Yes 2 X No
	the h	Director	10e. Street and Number	EO	MADD	10f. Zip C	ode			10g. Citi	zen of What C	ountry?
	h with		3006 GALLERY PL	ACE, APT. T-	-3	20	0602			U.	S.A.	
	deat	Funeral		Was Decedent Ever in U Armed Forces?	S. 13.	Was Deceder	nt of Hispanic C	origin? (Spe an, Puerto F	cify Yes or No Rican, etc.)		14. Race - Ame Black, Whi	
96	Muthin 72 hours after death with the Maryla within 72 hours after death with the Maryla than "natural", or items 23s or 28s-1 ehov than "natural", or items 23s or 28s-1 ehov the Modical Examinar mast be notified at	by Fu	1 Never Married 21 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1□Yes 2□						HITE
() S	altimore, Interview Z IZ IZ-15-0030 rmit. Pages 1 and 2 should be filed within 72 hours alt partment of Health and Mental Hygiene. portant: if tiem 27 is marked other than "natural", or y injury or other traumatic event, the Medical Exami	ted	15. Decedent's Educ	ation	16a. Dece	dent's Usual (Occupation	ost of workin	ıa	16b. Ki	nd of Business	/Industry
7	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			done during mo retired)		9			
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الح	IOCE, INTERVIBING ZIZID-Uges 1 and 2 should be filed within 72 hr to Health and Mental Hygiene. If Item 27 is marked other than "nature ovent, its Medical or other traumatic event, its Medical	Be		t MON								
-	aryla should ind Meni marke	٦ ر	ELLIS LEVI KI: 19a. Informant's Name/Relationship (Typ		19b. Mailin	ng Address (S	Street and Num				DERSO	
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Jan.	S 1 a s 1 a		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name	of		ate		cation - City or	
	Page Page nent c		1 Burial 2 □ Cremation 3 □ Re 1 □ Donation 5 □ Other (Specify)		PETERS	S CEMI	ETERY	1-17	-04	WALD	ORF, M	ARYLAND
2	Daltimore, Me permit. Pages 1 and 2: Department of Health as Important: If tem 27 is any injury or other traugings.		21. Signature of Funeral Service License	M00479			Address of Fac D FUNE	-	SERVI	CE,P	. A .	
17	1		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the deat	h. Do not em	er the mode	ra, Mar	YLAN	Prespiratory a	16.		Approximate Interval Between
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	bo, be executed sician and burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):							
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(ob rtifical ng phy as th	Jedi	IE EENALE.									
,	JIVISION Of VITAL RECORDS, P.O. BOX 08/00, or Attending Physician: The law requires that the death certificate be extified death. Director: After this certificate has been signed by the attending physician in by the funeral director, page 2 should be detached for use as the burial	by Physician/Me	in the past 12 months?	Sc. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of o	I death 3	Ectopic preg				2	23d. Date of de Month	livery Day Year
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	s bee	Completed							24a. Was		24b. Were a	utopsy findings available completion of cause of
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3	OT V Physic this ce al dire	To	1 Yes 2 No		ER/Outpaties						6 □Other (Spe	ecify)
	OD C	tion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 286	c. Injury at Work? 1 Tyes 2		8d. Describe	how injur	y occurred	
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	Hospite 24 hours Funera etely fille	edical C		ician: To the best of my known: On the basis of examination and manner stated.								
	To the within Fo the	Me	29b. Signature and title of certifie	0		1	License numbe			29d. Dat	e signed (Mon	th, Day, Year)
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			30. Name and address of person who ob							V.	+1	
-			Robert T. Pace,M			e Ctr	., Sui	te 2	02,21) Wa	1dorf	,MD 20602
	Sta	ate	31. Date filed (Month, Day, Year)	32. Begistrar's Sign	ature	paster)						

			For State Registrar	State o	f Marylan	d / Depa <i>Cei</i>	artmei <i>rtifica</i>	nt of Heal te of Dea	th and Nath	Mental Hy	gien Reg. N	2004	01570		
ı	Physicia		1. Decedent's Name (First, Middle, Last CORA BRODES	LEG	ATES					2. Date of De Month Januar	D	ay Yeer 2004	3. Time of Death 2:02 P M		
	/Medic Examin		4e. Fecility Name (If not institution, give		4b. City	, Town, or Loca	tion of Death			c. County of Deat					
			Caroline Nursi			Denton				Carol					
I	Funeral		5. Social Security Number 6. Security Number 1	() Yrs.	ff Unde Months		nder 24 Hrs. ours Min.	8. Date of Bi	rth ey Yea	9. Birthplace (Stete or Foreign Country)					
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100	yland Now		10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits		
	Mar.	io	MD Caroli	ne				Dent	on			1 ⊋ Yes 2 □ No			
	th the	Director	10e. Street and Number				101. Z	ip Code		10g. C	itizen of What Co	ountry?			
	ath w		520 Kerr Avenu					21629	0::-0/0		nited 14. Race - Ame				
	lterne Datur	Funeral	11. Marital Status 12. Was Decedent E Armed Forces? 1 Never Married 2 Married 1 Yes 2 N			If Yes, specify Cuban, Mexican, Puerto Ric						Black, Whit			
2	irs aft	by F	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give			1 ☐ Yes 2 ☐ No Specify:					Specify: V	hite		
5	72 hou	ted	15. Decedent's Ed	16a. Dece	dent's Us	ual Occupation	most of won	16b.	. Kind of Business/Industry						
1	ithin 7 be.	Completed	(Give kind of work dor life. Do NOT use retired to the complete of the complet						,	9	TT	1			
4	be filed within 72 hours after death with the Maryland the Hygiene. The Hygiene of other than "naturel", or Items 23s or 28s-f show do there than "naturel", or Items 23s or 28s-f show event, the Madical Examinar must be notified at		17. Father's Name (First, Middle, Last)			CT	erk	18 A	Mother's Nam	ne (First, Middle		echt Co	mpany		
	s 1 and 2 should be filed within 72 hours after death with the Marylan I Head and Member and Member I Head and Member I Head and Member I Head and Member I Head and) Be	John Henry Bro	des					Edith						
, i	2 should and Men ie marke aumatic	ို	19a. Informant's Name/Relationship (7	19a. Informant's Name/Relationship (Type, Print)								or Town, State, 2	Zip Code)		
M	and 2 : ealth ar m 27 ie		Mamie L. Phill	ips/Da	aughter	111	Sun	set B1	vd	Presto	on.	MD 21	655		
ָ נ	of Hear		20a. Method of Disposition		20b. P	lace of Dispo	sition (Na	ame of		Date		Location - City or			
	Pages nent of H ant: If ite ury or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify			nior	Ord	er Cem	. 1/1	0/04	Pr	eston,	Maryland		
Dall	permit. Pages 1 and 2 Department of Health a Important: If item 27 ie any injury or other tra once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility P. O. Box 43, Federalsburg Framptom Funeral Home, PA 21632										alsburg, MD 21632		
	45411		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximat										Approximate Interval Between		
F	Physician		fmmediate Cause (Final disease or condition	Rev	7 1an	21/10	e						Onset and Death		
	/Medical Examiner		resulting in death)	uence of):											
	E x	J.	Sequentially list conditions,	uence of):	~										
	rted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ine	_										
	execunation and ial-tra	Exa	that initiated events resulting in death) Last	uence of):											
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0	ing ph		IF FEMALE:												
5	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?							23d. Date of delivery Month Day Ye					
	he de	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown												
	that the ded by detact		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute								use contribute to	the cause of death?			
25	quires n sign	d by	0500							1 🗆	2 Probably 4 Unknown				
2	s bee	olete					24a.					24b. Were au	autopsy findings available to completion of cause of		
24a. Was an autopsy performed? 1 Yes 29No								death?							
פ	ian: artifica ctor, p	BeC	25. Was case referred to medical examiner?						Place of Dea	ith (Check only	-				
>	hysic his ce	10	1 ☐ Yes 2 No		· · · · · · · · · · · · · · · · · · ·	ER/Outpatier			Nursing H		me 5 Residence 6 Other (Specify)				
5	ing P	on:	27. Manner of Death 12 ■ atural 5 □ Pending		of Injury oth, Day Yeer)	28b. Time o Injury		28c. Injury at Work?	2 🗆 No	28d. Describe	28d. Describe how injury occurred				
2	death death stor:	icat	2 Accident Investigation 3 Suicide 6 Could not be	ome farm sti						(Street and Number or Rural Route Number, own, State)					
	after Direction by	Certification:	4 Homicide determined	y)											
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifier (Check only one) Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) Check only one) Check only one) Addical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									s stated. e to the cause(s)			
	o the	Me	29b. Signature and title of certifier		29c. License number					29d. Date signed (Month, Dey, Year)					
	->-0				7	00053	255	\	18/04						
			30. Name and address of person who	completed cau	se of death (Iten	n 23a) (Type,	Print)								
			Melind = Butle	2 315	81000	rmzg	ماما	Dere &	redo-	00/3/01	~~>	wo o	2¢ 2) (
	Sta Registi		31. Date filed (Month, Day, Year)	14 32.	Registrar's Signa	M. A.	ast.	,							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth Month Day Physician Edna Jeanette Lutz January 9 2004 /Medical 1455 4b. City, Town, or Locetion of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Denton If Under 24 Hrs. Ruxton Health of Denton Caroline If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1 M 2 F Yrs. Director 218-20-9170 Usuel Residence of Decedent December 21, 1926 Maryland permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Merylend Department of Haaith and Mental Hygiena. Important: if Item 27 is marked other than *natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1□Yes 2□No Director Maryland Caroline Denton 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 316 South Third Street 21629 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Black, White, etc. - American Indian. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 2 1 ☐ Yes 2√2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <u>Deputy Treasurer</u> Government 11 HS Grad 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Kemp Medford Eva Mae Layton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Leslie F. Lutz</u> 316 South Third Street, Denton, Maryland 21629 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Capitol Crematory 1/13/04 Dover, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Moore Funeral Home, P.A. Lack 12 South Second Street, Denton, Maryland 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Carcenona Examiner Due to (or as a consequence of) Examiner attending physician end for use es the buriel-transit Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the µnderlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 20 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours aftar death.

To the Funeral Director: After this of completely filled in by the funeral director. 27. Manner of Death 1 Naturel 28b. Time of Injury 28c. Injury at Work? 28e. Dete of Injury (Month, Dey Year) Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 111 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

2 JAN 2004

4NDREA ALLEN

31. Dete filed (Month, Day, Year)

and eddress of erson who completed cause of death (Item 23e) (Type, Print)

0

32 Registrar's Signature

21

		•	For State Registrar	State of M	laryland		artmen rtificate				F	leg. No.	004	015	72	
I	Physici	an	1. Decedent's Name (First, Middle, Las Constance Margue		n						2. Date of Dea Month January		200 ² 4 ^{ar}	3. Time of 0	Death PM	
20	/Medic	al	4a. Facility Name (If not institution, give				4b. City,	Town, or	Location o		702-1-02-1	1	unty of Death			
	Examin	er	1804 Severn Grov		A	nnapo	lis		Ann	e Arun	ındel					
16 (2)	Funeral Director		113-20-0400	9x □M 2 ⊠ F	ge (In yrs. Ia 100	st birthday) Yrs.	If Under Months	1 Year Days	If Under a	Min.	B. Date of Birtl (Month, Day March	(Year) 9. Birthplace (State or Foreign Country) Fingland				
Maryland 21215-0036	Maryland I-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Art	Town or Lo	Annapolis					10d. Inside Ci 1 ☐ Yes						
	h with the	al Dire	10e. Street and Number 1804 Severn Grov	ve Road			10f. Zip Code 21401					_	of What Cou nited	_{ntry?} Kingdor	n	
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Medical Exama or must be routled at	by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	t Ever in U.S ?]No :	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						14. Race - American Indian, Black, White, etc. Specify: White			l:		
	within 72 ho lene. 'then "natur the Nedical	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Practical Nurse								ng 16b. Kind of Business Nursing			ndustry		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If Item 27 Is marked other than "natural", or Itemas 28a or 28a-1 show any injury or other traumatic event, Ita Madical Exama for minist be notified at ODGs.	To Be C	17. Father's Name (First, Middle, Last) William Loan 18. Mother's Name (First, Middle, Maiden Sumame) Grace Rhodes													
			19a. Informant's Name/Relationship (7 Bill Buck/nephe			19b. Maili 1804	ng Address Sever	(Street a	ove F	er or Rural Road	Annapo	e Number, City or Town, State, Zip Code) nnapolis, MD 21401				
nore,			20a. Method of Disposition 1 □ Burial 2 ☐ Fernation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	e ce	ace of Disponentery, cre-	matory or o	ther place			Date 20c. Location - City or Town, State 8/2004 Baltimore, MD					
Baltimore,			21. Signature of Funeral Service Licen		ille	7 2	2. Name ar	nd Addres	s of Facilit	Joh	n M. Ta	ylor	Funera		401	
.O. Box 68760,	Physician /Medical Examiner per prigit (rausit	icai Examiner	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Bray Due to (or a b. Due to (or a c. Ash	is a consequence of a c	leros ience of):	Infa 515	xcti	<u>On</u>					Interval Betwonset and C	2a15	
	The law requires that the death certificat ite has been signed by the attending phy page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		Ectopic pregnancy Other (specify)					23d. Date of delivery Month Day Year						
<u>α</u>	uires that n signed b ild be deta	by	Part II. Other significant conditions of	The Other significant series of the series o									cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown			
Vital Records,		Completed	24a. Was an autopsy performed? 1										ompletion of ca	available ause of		
Vita	Physician: Th this certificete ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:		EB/Outpotio	2 N	Oth	00		(Check only o		Other (Spec	i6.0		
on of	ling After fune	 -	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Work?												
Division	el or Attendii after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	200. Flace 01	Be. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospitel or Att within 24 hours after d To the Funeral Direct completely filled in by	edical C		nysician: To the be miner: On the basis and manner	of examinat)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	11 0	(7	29	c. Licens	e number	10		29d. Date s	igned (Month	, Day, Year)		
			Kichan &	Joahn	lare	Wil	Seizet)	00	51	42		8//1	12/0	4		
			30. Name and address of person who	completed cause of	M.D	25a) (Type	-Wa	rde	urT	Driv	e. An	navell	5 mil.	2140	01	
Y	St Regist	ate rar	31. Date filed (Month, Day, Year)	2004	trar's Signa	ture	hour				7.7.	1			t	

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Rebecca Jordan Lidard 2004 January 5, /Medical 11:30 a. 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis
If Under 1 Year | If Under 24 Hrs.
Wonths | Days | Hours | Min. Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthdey) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 2√2 F Months 225-84-3769 49 Director October 18,1954 Virginia Usual Residence of Decedent r 28a-f show 10b, County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or the Medical Examiner rount be 3213 Black Walnut Drive 21403 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No or items 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black White etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes Give 1 ☐ Yes 2 XNo Specify: þ Specify: 3 Widowed 4 Divorced Year or Dates: White "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Territory Manager 12 Publishing filed permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth eny july or other treumatic event 2008: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Henry P. Jordan June Deyson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Husband) Gary M. Lidard 3213 Black Walnut Drive Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bestoate Memorial Park Jan. 8, 2004 Annapolis, Maryland 22. Name and Address of Facility Adams Funeral & Memorial Care 21. Signature of Fyneral Service Licensee M00982 814 Bestgate Rd. Annapolis, Maryland 21401 1 80 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** luteral Sclerosic yo trophe 76mo /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner -transit or Attending Physicien: The law requires that the death certificate be executed physician ar s the burial-t Due to (or as a consequence of): Box 68760. Physician/Medical attending physical for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) ed by the a o ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ neumouia Completed 3 Probably 4 □Unknown page 2 should 2X No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 🗆 Yes Division of Vital 1 ☐ Yes 2 No 2 No funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 🗌 Pending within 24 hours after death. To the Funerel Director: A 2 Accident investigation 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospitel 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifie 29c. License number 124804 - MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMS Annapelis Med 2146/ Peterson MD 31. Date filed (Month, Day, Year) 32. Rastrar's Signature 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 5, **Physician** January 2004 6:40A. M VIOLET CELESTE LEE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Cuppett Weeks Nursing Home Oakland Garrett 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 K F Yrs. OCT MARYLAND 91 30, 215-80-7995 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or Items 23s or 28s-f show the Medical Exactings must be notified at 1 ☐ Yes 2 No MD GARRETT OAKLAND Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21550 USA 223 MASON SCHOOL ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐Yes 2 X No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) al Hygiene. College (1-4or 5+) OWN HOME HOMEMAKER permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If item 27 1s marked other th any injury or other traumatic avent, the once. 18. Molher's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be SARAH JORDAN FOSTER JUDSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) OAKLAND, MD 21550 SHIRLEY COSNER - DAUGHTER 266 MASON SCHOOL ROAD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 △Burial 2 □ Cremation 3 □ Removal from State GARRETT MEMORIAL GARDS. 1/7/04 OAKLAND, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Arryica 22. Name and Address of Facility P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550 M00167 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician l Week Acute Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, Alzheimer's Dementia 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has autopsy performed? Yes 20 No 1 Yes certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2X No this After thi 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: / 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide hours after within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier To the Fune completely fi (Check only one) and manner stated. 29b. Signature and the or certifier 29c. License number 29d. Date signed (Month, Dey, Year) Mo D0033464 January 5, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Coughlin, M.D. PO Box 8, Eglon, 26716 Robert M. 32. Registrar's Signature 31. Date filed (Month, Day, Year) JAN 0 6 2004 Registrar

			1 - For Stete Registrar	State of M	arylan	d / Depa <i>Cei</i>	artmen rtificat	t of H e of L	lealth a Death	and M		giener	2001	+ 01575
Ī	Physici	an	1. Decedent's Name (First, Middle, Last)								2. Date of De. Month	ath Day	Year	3. Time of Death
1	/Medi		Ola Augustine Lar								January	6	2004	7:00 A M
4	Examir	ner	4a. Fecility Name (If not institution, give s)				Location of				County of De rederi	
			Vindobona Nursing 5. Social Security Number 6. Sex		00 //0 v/rc	last birthday)		1 Year	ck He	_				
	Funeral Director			M 2□F	87	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da Aug 18	y, Year)	9. B	irthplace (State or Foreign Country) adiz, Kentuck
			Usual Residence of Decedent		07						Aug 10	191	0 Ca	idiz, Kentuck
	yland		10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	a Mar	to	MD Frederic	k	I	3runsw	ick							1 X Yes 2 ☐ No
	or 28	ire	10e. Street and Number				10f. Zip	Code				•	en of What (Country?
	filed within 72 hours after death with the Maryland Hygliene. Ither than "natural", or flems 23s or 28s-f show ther than Medical Evaminar must be notified at	Funeral Director	507 9th Avenue					2171	6			US.	A	
	r dez	Inel	11, Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13.	Was Deced	dent of Hi	ispanic Original	gin? (Spe	ecify Yes or No- Rican, etc.)	- 14	1. Race - An Black, Wh	nerican Indian, nite. etc.
36	or it	Y F.	1 ☐ Never Married 2 ☑ Married	1 Yes 2 📆			1 🗆 Yes		Specify:		•	Ì	Specify:	White
21215-0036	hour:	d by	3 Widowed 4 Divorced	Year or Dates:		450 Dans	da ada Harri							
75	n 72 "nat	Completed	15. Decedent's Edu (Specify only highest grade			16a. Deced (Give	kind of wo DO NOT us	nk done d se retired	ation du <i>ring m</i> osi ()	t of worki	ng	16b. Kind	d of Busines	s/Industry
12	with ene. than	E C	Elementary/Secondary (0-12)	College (1-4or	5+)	Engin			,			B&O	Chess	sie
0	Hyg Other ent,		17. Father's Name (First, Middle, Last)			13118 1111			18. Mothe	er's Name	(First, Middle,	Maiden S	umame)	
a	ld be ental ked ked ic ev	To Be	Wadford Lancaster	•					Sero	nia	Vanzant	:		
Maryland	3.2 should be fited within "h and Mental Hygiene." 7 Is marked other than "I traumatic event, the Me.	-	19a. Informant's Name/Relationship (Type	oe, Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	I Route Numbe	r, City or	Town, State,	Zip Code)
	alth a		Dan K. Lancaster	, Son		4115	Burk	itts	ville	Roa	d, Knox	vill	e, MD	21758
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or items 23s or 28a-f show any injury or other traumatic event, the Medical Evarinet must be notified at ance.		20a. Method of Disposition			lace of Dispo	sition (Nan	ne of ther place	e)		ate	20c. Loca	ation - City o	or Town, State
Ë	Page net: M		1 ☐XBurial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State)	rk Hei	•			1/9/	04	Bru	nswic	k, MD
aĦ	permit. Departmine importa any injugence.		21. Signature of Fundral Service License	6 1/1/	lini	~ 22	. Name an	d Addres	s of Facilit	v				
@	88 = 8		Barbara A. Wil	liams, Ov	mer	1	onn 1 00 Pe	ters	ville	ns ru Roa	ineral H id, Brun	iome iswic	k, MD	21716
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that cause e cause on each li	d the death									Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Pne	11111	unia	,							Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequ	uence of):					1			a fin
ш	Examiner		Sequentially list conditions											
	ס ב	iner	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that is listed exects.	Due to (or as	a ecnesqu	senes of):								
	and and trans	Examin	that initiated events resulting in death) Last											
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		,	Due to (or as	a consequ	ience or):								
87	physi the t	Physician/Medical	d											
9 x	death certifica attending ph d for use as th	Me /Me	IF FEMALE:	3c. If yes, outcome	of oregina	nev								
Вох	atten tor u	lan	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	Ectopic pr Other (sp					23	d. Date of de Month	Day Year
P.O.	that the de ed by the detached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	t title of de	54U1 J_	J Other (Sp	ocny/						
	res that the signed by be detact		Part II. Other significant conditions con	tributing to death b	out not resu	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did to	bacco use	contribute	to the cause of death?
Records,	uires sign id be	d by	Dementio	_ St	WK						1 🗆 Y	es 2 🕏	No 3□F	Probably 4 Unknown
Ö	w requir been si should	Completed									24a. Was	20	24h Ware a	utopsy findings available
Re	The lav	E G									autop	sy	prior to death?	completion of cause of
ē			25. Was case referred to medical						00. 51			2 No	1 🗆 Ye	s 2□No
of Vital	Physician: r this certifica rat director, I	o Be	evaminer?	ospital:	ont 2 🗆	ER/Outpatien	t 3 🗆 DO	Othe	-		<i>(Check only o</i> ne 5∐ Resid		70th == (C-	
	ding Physician: n. After this certific funeral director,	ι: To	27. Manner of Death	28a. Date of Inju		28b. Time of		8c. Injury Work			28d. Describe h			eciry)
o	nding f th. :: After e funer	gio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year)	Injury	М		:? /es 2 □ N	No				
Division	I or Attandi after death. Director: A in by the fu	ij	3 Suicide 6 Could not be determined	28e. Place of Inj	jury - At ho	me, farm, str	eet, factory	, office		2			Number or F	Rural Route Number,
Ö	s afte	Certification:	4 Notticide	building, et	с. (<i>эрөсп</i> у	"					City or Tow	n, State)		
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical (29a. Certifier 11 Certifying Phys (Check only one)	ician: To the best er: On the basis o and manner st	of examinat	wledge, death ion and/or inv	occurred restigation,	at the tim in my op	e, date and pinion, deat	d place, a	and due to the o	ause(s) ar	nd manner a lace, and du	s stated. e to the cause(s)
	othi othio	Me	29b. Signature and title of certifier				290	. License			2	29d. Date :	signed (Mon	th, Day, Year)
1	->- o			nn-				DY	716	19		1	-8-	04
	1.		30. Name and address of person who co	mpleted cause of a	death (Item	23a) (Type	Print)			-/-				/
	6		HO, CHAN-HI	11-	1.17.		610	gt	4 A	ve.	Brunsi	wick	, MD	21716
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registr	rar's Signat	ture	,	,	/ .:				-	
	Registr	ar	JAN - 9	2004	Ganar	na	9	10	acks	/				

State of Maryland / Department of Health and Mental Hygiene 2004 01576 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1 - 3 - 048:15 P. M Carol Jean Lane /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Mitchellville Prince George's Villa Rosa Nursing Home If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number **Funeral** 1 ☐ M 2 🖾 F 82 4-2-1921 Wash.. D.C Director 579-18-4055 Usual Residence of Decedent 10d. Inside City Limits deeth with the Maryland 10c. City. Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f ahow the Medical Examinar must be notified at 1 Yes 2 No Director Bethesda Montgomery 10g. Citizen of Whal Country? 10e. Sfreet and Number 10f. Zip Code U.S.A. 20817 5815 Walton Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black. White, efc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examina 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White <u>م</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Agnes McGarraghy Chapin Bauman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8965-C Early April Way, Columbia, MD 21046 David Lane - son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or o 1-7-04 Silver Spring, MD * 4 □ Donation 5 □ Other (Specify) Gate of Heaven 22. Name and Address of Facility Hines-Rinaldi F. H. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 48 hours **Physician** ASPIRATION PHEUMONIA disease or condition resulfing in death) /Medical Due to (or as a consequence of) Several Examiner muttiple cesebro vascular accidents mon ths Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequ Examine The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown senite dementia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 | Inpatient Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 3 DOA Certification: To 2 ER/Outpatient After this of 27. Manne of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a t 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D22780 1-5-2004 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greenway Ctr. Dr. Greenbelt, MD 20770 M Schissle 7500 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 6 2004 Seneva Registrar

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey **Physician** 6:00 A M Marion Patricia LaTendresse 2004 January 3, /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7620 Old Georgetown Road, #210 Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F 213-56-8880 81 March 5. Director Canada Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Montgomery Maryland Bethesda Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7620 Old Georgetown Road, #210 Items 23a 20814 United States death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or liamany injury or other traumate. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame) Be Edward Joseph Hanrahan Marion Gorman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) T. Lorraine LaTendresse/Daughter 4719 Wyaconda Road, Rockville, Maryland 20852-2439 20b. Place of Disposition (Name of cometery, crematory or other place)
Gate of Heaven
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State January 6, injury or 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, 4 Donation 5 Other (Specify) 2004 Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 21. Signature of Funeral Servic Licenses M00689 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart aillure. List only one cause on each line. Approximate Interval Between Onset and Death Part 1. shock Immediate Cause (Final **Physician** Late effects of Cerebral Vascular Accident resulting in death) /Medical Due to (or as a consequence of): **Examiner** T-cell Lymphoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown á Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ò Recurrent Aspiration Pneumonia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Chronic Obstructive Pulmonary Disease has certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 ☑ No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 K Natural 5 Pending 1 ☐ Yes 2 ☐ No death 2 Accident investigation within 24 hours after death To the Funerel Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Š 4 \(\text{Homicide} \) 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature an title of certifier 29c. License number 29d. Date signed (Month, Day, Year) pris D35579 January 5, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6844 Tulip Hill Terrace, Bethesda, Maryland 20816 Susan J. Miller, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 6 2004 Registrar

, 0		30. Name and address of person the	completed cause of deat	n (Item 23a) (Type	, Print)				
10 10		·CAS	L	MI	D3563			ANUARY 2 .	
# 등 # 등	Medical	(Check only one) 2 Medical Exemone) 29b. Signature and title of partifier	ysicien: To the best of miner: On the basis of ex and manner stated	amination and/or i	nvestigation, in my o	pinion, death occur	red at the time, da	ause(s) and manner ate and place, and di Date signed (Mo.	ue to the cause(s)
e Hospital or Attending 124 hours after death. a Funaral Director: After letely filled in by the fune	Il Certification:	3 Suicide 6 Could not by determined	28e. Place of Injury building, etc. (Specify)	treet, factory, office		City or Town	, State)	Rural Route Number,
ig Phy ter this teral d	2	1 Yes 2 No 27. Manner of Death 1 No Natural 5 Pending 2 Accident investigation	Hospital: 1 N Inpatient 28a. Date of Injury (Month, Day Yo	2 ER/Outpatie 28b. Time Injury	of 28c, Injur	er: 4 🗆 Nursing Ho		nce 6 Other (Sp	pecify)
The lay ate has page 2	Be Completed	25. Was case referred to medical examiner?				26. Place of Deal	24a. Was an autops perform 1 Yes 2	y prior t ned? death XINo 1 □ Y	autopsy findings available o completion of cause of ? es 2 \(\text{No} \)
requires een sign nould be		Significant conditions o	ontributing to death but h	ot resulting in the	underlying cause giv	en in Part I.	1 🗆 Ye	os 2 X No 3□	to the cause of death? Probably 4 Unknow
death certif e attending ed for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 2 [4 Pregnant at tim	Fetal death 3 se of death 5	□Ectopic pregnanc: □ Other (specify)			23d. Date of o	Day Year
icate be executed physician and s the burial-transit	dical Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. CEREBRAL Due to (or as a c	PALSY					YEARS
Examiner	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a control of the contr						1 MONTH
Physician /Medical		23a. Part 1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. METASTAT	C PROSTA			or respiratory arri	est,	Approximate Interval Between Onset and Death YEARS
permit. Departn Importa any inju		21. Signature of Funeral Service Licer	ideuxa	T	22. Name and Addre ANZANSKY- 170 ROCKV	SS of Facility GOLDBERG TLLE PIKI	MEMORTAL E, ROCKVI	L CHAPELS	INC.
Pages 1 and Her Intro of the Intro of the		20a. Method of Disposition 1 Magurial 2 Cremation 3 C 4 Donation 5 Other (Specif	Removal from State	20b. Place of Dis cemetery, cr	position (Name of ematory or other pla	се)	Date	20c. Location - City ADET PHI	or Town, State
and 2 should saith and Men n 27 is marke ier traumatic	2	19a. Informant's Name/Relationship (JAMES WALKER/ COU	Type, Print)			and Number or Ru		WALKI r, City or Town, State BEACH: SC	e, Zip Code)
d be filed intal Hygie ed other	Be Co	8 17. Father's Name (First, Middle, Last, MARX	LEWIS	NONE		18. Mother's Nam	ne (First, Middle, i	· ·	
within 72 lane. Ihan "nat	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Gin	edent's Usual Occu ve kind of work done DO NOT use retire	during most of wor	king	16b. Kind of Busine	ss/Industry
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itame 23e or 28e-f show any injury or other traumatic event, the Medical Examinat must be trofilled at once.	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Even Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	er in U.S.	3. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No No		pecify Yes or No- o Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, /hite, etc.
ath with the 23e or 2	ral Dire	10e. Street and Number 10921 INWOOD AVEN	NUE #206		10f. Zip Code 20902			IOg. Citizen of What	Country?
e Marylar Ba-f show	Director	10a. State 10b. County MARYLAND MONTGOMI		Oc. City, Town or STLVER SI					10d. Inside City Lim 1 ▼ Yes 2 □
Director		Usuel Residence of Decedent	1 X M 2□ F	74 Yrs.	Months Days	Hours Min.	(Month, Day 03/21/1	1929 NEI	V YORK
Funeral		-	Sex 7. Age (In yrs. last birthda				MONTGOME:	RY Birthplece (State or Fort Country)
/Medi Examir		I.TONFI, Z. I.EWTS 4e. Fecility Name (If not institution, given in the content of the content o	re street and number)		4b. City, Town,	or Location of Deat	TANUARY	2 2004 4c. County of C	635 a
Physic	an		ist <i>)</i>				2. Date of Dea Month	Day Ye	
		1. Decedent's Name (First, Middle, La	41						

			Flease	• •	aryland / Dep				ene	•
			for State Registrar	Otato of int		rtificate of			g. No. 200	4 0 579
			Decedent's Name (First, Middle, La.	it)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	al	Susan B. Lipuma					1-6-2004		11:09 A. ^M
	Examin		4a. Facility Name (If not institution, give	_			or Location of Deat	th	Montgom	
			Holy Cross Hospi 5. Social Security Number 6. S		e (In yrs. last birthday)		If Under 24 Hrs	8. Date of Birth	Montgome 9. B	irthplace (State or Foreign
Н	Funeral Director			□M 2⊠F	81 Yrs.	Months Days	Hours Min	8. Date of Birth (Month, Day, 1-24-22	Year) NJ	Country)
	D.		Usual Residence of Decedent		10c. City, Town or L	tion				10d. Inside City Limits
	arylar show	L.	10a. State 10b. County							1 ☐ Yes 2 ☐ No
	the M	ecto	MD Montgom 10e. Street and Number	ery	Silver S	opring 10f. Zip Code		10	g. Citizen of What C	Country?
	with Mark	급	1204 Schindler I	r.		,	903		U.S.A.	
	death ma 23	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H	Hispanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh	
336	s 1 and 2 should be fited within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or itema 23s or 28s-f show other traumatic event, the Medical Examers must be notified at	ρ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 XI If Yes, Give Year or Dates:	No	1 ☐ Yes 2 ☑ No		10 (1104), 51017		White
2-0	72 hor	ted	15. Decedent's E	fucation de completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wo	orking 1	6b. Kind of Busines	s/Industry
21215-0036	vithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	<i>DO NOT</i> use <i>retire</i> emaker	d)		Home	
C	filed v Hygie other t		17. Father's Name (First, Middle, Last,		Hom	emaker	18. Mother's Na	me (First, Middle, M		
an	ould be Mental arked o	To Be	Andrea Bongianni				France	sca DeVic	0	
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Ma	-	19a. Informant's Name/Relationship (19b. Mail	ing Address (Street	and Number or R	ural Route Number,	City or Town, State,	Zip Code)
	1 and 2 Health a tem 27 is		Anthony C. Lipum	a - Son				er Spring		
ore	P 0 = 53		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	20b. Place of Disp cemetery, cre				0c. Location - City o	
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other troops.		4 Donation 5 Other (Special	*		coln Crem	<u>-</u>	ines-Rina	Bladensbu	rg, MD
Bal	permit. Pag Department Important: any injury once.		21. Signatur of Fune al Service Lice) u						ring, MD 2090
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death Do not an					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		c arrest					Onset and Death
18	/Medical Examiner		resulting in death)		a consequence of):					
	LXammer		Sequentially list conditions,	b. Hypert	ension a consequence of):					
	nsit	Examlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or triury	,	atory infe	ction				
Ć.	te be executed ysician and re burial-transit	Еха	that initiated events resulting in death) Last	C	a consequence of):					
1760,	Ite be tysicia ne bur	cal		_ d						
68 ×	artifica ing ph e as th	Physician/Medi	IF FEMALE:	20 1/						
Вох	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death 3	☐Ectopic pregnanc☐Other (specify) _	у		23d. Date of d Month	elivery Day Year
o.	y the c	yslo	1 ☐ Yes 2 🔯 No 9 ☐ Unknown	9☐ Unknown	time or doubt					
σ.	The law requires that the death certificate be executed the has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	by Pr	Part II. Other significant conditions	ontributing to death b	ut not resulting in the	underlying cause gr	ven in Part I.	23e. Did toba	acco use contribute	to the cause of death?
of Vital Records,	w require been sig should b	ed t						1 Tes	s 2 No 3 F	Probably 4 Dunknown
ecc	law re as be	Completed						24a. Was an autopsy	prior to	autopsy findings available completion of cause of
E R		Соп						perform 1 Yes 2		s 2 No
Vita	sicien: The law certificate has l irector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		Otto	hac	ath (Check only one		
ō	Phys r this ral di	: To	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ent 2 ER/Outpatie	111 3E DOA	4 🗆 Hursing	Home 5 Resider 28d. Describe hov		ecity)
ion	nding ath. r: Afte e tune	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		y Year) Injury		rk?]Yes 2∐No			
Division	r Atte	tific	3 Suicide 6 Could not to determined	250. Place of III	ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
	urs aft ral Di	Cer								
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director;	edical Certification:	29a. Certifier 1 → Certifying P (Check only 2 → Medical Exa	nysicien: To the best miner: On the basis o and manner st	of my knowledge, dea f examination and/or is ated.	th occurred at the ti nvestigation, in my	me, date and place opinion, death occ	e, and due to the car curred at the time, da	use(s) and manner a te and place, and di	as stated. ue to the cause(s)
	o the	Me	29b. Signature and Ittle of centries			29c. Licen	se number	29	d. Date signed (Mor	nth, Day, Year)
	10		> %//-			5	9775		1/7	104
	i,		30. Name and andress of person who						1 - /	
			Zaih Shanavas M.D			#20, S:	ilver Spi	ring, MD 2	0901	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	04 32. Hegisti	rar's Signature	Sparks				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month January 3, 2004 Cheng-Wen 1:55 AM /Medical 4a Fecility Name (If not institution, give street and number) 4b. City. Town, or Locetion of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1⊠M 2□ F Yrs Director 100-62-5837 June 27, China Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1⊠ Yes 2 No Director Westbury New York | Nassau 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 455 Newton Street 11590 United States 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Shipping Clerk Sign Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ji-Quang Liu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Chao Liu/Wife 11801 Rockville Pike, # 802, Rockville, MD. 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/7/04 Alexandria, Virginia Metropolitan Crematory 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licenses O East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final diseese or condition resulting in death) Prevmonia /Medical week Examiner Due to (or as a consequence of): Examiner attending physician and for use es the bunal-trensit or Attending Physician: The lew requiras thet tha daath certificate be axecuted Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 20 No 3 Probably 4 Unknown ģ within 24 hours after deeth.

To the Funeral Director: After this cartificate has been si completely filled in by the funerel director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? TUYES 26No 1 ☐ Yes 2 1 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Appatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2500 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 3, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical center Dr. Kockville, M Mutthew Pottenroth 9901 W 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 0 7 2004 Registrar

			For State	State of Ma	aryland /		artment of H <i>tificate of I</i>		Mental Hy	/giene Reg. No		01581
			Registrar 1. Decedent's Name (First, Middle	, Last)					2. Date of D	eath		3. Time of Death
	Physicia /Medic		Catherin	e Dargan I	_loyd				Janua:	ry 8,		5:00 A M
-an-	Examin		4a. Fecility Name (If not institution	give street and number)			4b. City, Town, or	Location of Death	1	40	. County of Deeth	
			8503 Victory 1				Potoma		T (5		Montgome	
	Funeral Director		5. Social Security Number 217-46-5528	6. Sex 7. Ag	e (In yrs. last b		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D Dec • 18		9. Birth Cou	place (State or Foreign intry) .shington, DC
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits
	ehor e hor	5	Md. Montgo	nm 0 12 17	Potom							1 ☐ Yes 2Ã No
	28a-1	Funeral Director	10e. Street and Number	omery	1000	iac	10f. Zip Code			10g. Cit	tizen of What Cou	intry?
	3a or		8503 Victory	Lane			2085	4			U.S.A.	
	death	era	11. Marital Status	12. Was Decedent	Ever in U.S.	13. \	Was Decedent of H I Yes, specify Cuba		pecify Yes or N	0-	14. Race - Amer	
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show emportant: If item 27 is marked other than "natural", or items 23a or 28a-f show employed on the majory of the traumatic event, the Madical Examinar must be notified at once.	by Fur	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? ed 1 ☐ Yes 2 ☐ Yes, Give Year or Dates:	No	1	1 Yes, specify Cuba 1 □ Yes 2 🔀 No	Specify:	o rican, etc.)		Black, White Specify: Whi	
200-c	2 hou atura		15. Decedent	's Education	16	a. Deced	dent's Usual Occup	ation	ting	16b. K	(ind of Business/l	ndustry
<u> </u>	en "n Medi	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4or 5	5+)	life.	DO NOT use retired	i)	Kilig	·		
7	ed wil	Con	12			I	Homemaker		(E) . A41.44		Own Home	
yland	tal Hydrad oth	Be	17. Father's Name (First, Middle,					18. Mother's Nan	, ,		n Sumame)	
<u> </u>	I Men narke	၉	Andrew Darga			N= 8.4-111-	- Add (Caa	Bridge			Tourn Ctoto 7	in Cordo I
Mar	12 sh h and h snd 7 is m		19a. Informant's Name/Relations	(dauc	hter)		ng Address (Street					
e e	1 and Health em 2 ther		Catherine Ann	Lloyd Grundm	20b. Place	of Dispo	Happy Consistion (Name of		ne, GAi Date	ther 20c. L	Sbur Nocation - City or 1	d . 20878 own, State
פֿ	ages III To		1 X Burial 2 ☐ Cremation		1	-	matory or other place vet Cemet	Jan	. 12,	Wa	shington	D.C.
baitimor	artme ortani injury		4 □ Donation 5 □ Other (S)21. Signature of Funal Service		ML.		Name and Addre	se of Eacility	004			, , D. O.
Ö	Dep Period		1 Samen &	13/10/) East De	D.	eVol Fu Drive,			. Md.
	4		23a. Part 1. Enter the disease, or shook, or heart failure. List	complications that caused	the death. Do	_						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			ılar	Accident				Administration of the state of	Onset and Death 4 weeks
	/Medical		resulting in death)	a	a consequence							
	Examiner		Sequentially list conditions	b	1 Fibri		tion					Years
	D #	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence		01	1 D				X7
	and I-tran	xam	that initiated events resulting in death) Last	C	a consequence		Cardiova	Scular D	rsease			Years
8/60,	icate be executed physician and s the burial-transit	aiE		Hyper	tension	1						Years
20	ficate p phys	edicai		0.								
C. BOX	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal dea		Ectopic pregnancy Other (specify)	/	int -		23d. Date of deliving Month	very Day Year
J.	that hed by deta	by Ph	Part II. Other significant condition	ens contributing to death b	out not resulting	in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ras	requires seen sign hould be		Hypercholes	erolemia					1 🗆	Yes 2	X No 3 Pro	bably 4 Unknown
ecord	law reas bee	Completed							24a. Wa	s an	24b. Were aut	opsy findings available empletion of cause of
r	9 - 9	E O							per	formed?	death?	2 No
VII	ician: Th certificate rector, pag	BeC	25. Was case referred to medica examiner?					26. Place of Dea		- 41		- A
OI <	d is	2	1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatio		Outpatier		4	lome 57 Res	idence	6 □Other (Spec	ify)
	fte ne	ation:	27. Manner of Death 1 Natural 5 □ Pendir 2 □ Accident investi		ry Year) 28b	Injury	Wo	yat k? Yes 2 ☐ No	28d. Describe	how inju	ry occurred	
DIVISION	0 # 5 ⊆	Certification:	3 Suicide 6 Could 4 Homicide determ	inad 200. Flace of III	jury - At home, ic. (Specify)	farm, str	reet, factory, office			(Street ar own, State		ral Route Number,
	To the Hospitel within 24 hours a To the Funeral Completely filled	edical (g Physician: To the best Examiner: On the basis of and manner st	of examination a							
	To the within 2 To the comple	Me	29b. Signature and title of certifie	- a //			29c. Licens	e number		29d. Da	ate signed (Month	, Day, Year)
	4) Leton	Ston	m	M		32033		Janu	ary 8, 2	2004
	(30. Name and address of person Peter G. Hamm					#930. Ch	evv Cha	ise	Md. 2081	5
15,	Sta Registi		31. Date filed (Month, Day, Year)		rar's Signature		Spark		one	,	114. 2001	· -
					/	-	//					

(1	i ii	30. Name and address of person who P. Callahan - Lyon 31. Date filed (Month, Day, Year)	mo 911 32. Registrar's Signatu	Russ	ell Ave	. Gait	ters burg	ino	208	79
,	i		P. Callal	endyen			11794 . Gait		Tanuar	y 5,	2004
To the Hospital within 24 hours a	the Fune	Medical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of my knowl iner: On the basis of examinatio and manner stated.	n and/or ir	vestigation, in my	opinion, death occu	urred at the time.	date and place,	and due to	The cause(s) Day, Year)
Division Hospital or Attending 4 hours after death.	To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	building, etc. (Specify)				City or To	Street and Numb wn, State)		
on of ding Phys	After this funeral dia	tion: To B	examiner? 1 Yes 2 Yo 27 Manner of Death 1 Watural 5 Pending 2 Accident investigation		WOutpatie 8b. Time o Injury	f 28c. Inju			idence 6 Oth-)
ital Re ian: The la	certificete has ector, page 2	a)	25. Was case referred to medical				26. Place of Dea	perfe 1 ☐ Yes	2 No 1	leath?	2□ No
ecords, Flaw requires that	been sign should be	oleted by F	Part II. Other significant conditions of		ng in the u	nderlying cause gr	ven in Part I.		Yes 2 100	3 🔲 Proba	ably 4 [Unknown sy findings available apletion of cause of
O. Box 6	by the attending ached for use as	Completed by Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnanc 1 □Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3[th 5[Ectopic pregnanc Other (specify)		220 Did	Moi		y Day Year e cause of death?
	physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	nce of):	Damen	Ha			5	years
	sician edical		23a. Part1. Et the disease, or comp shock, o eart failure. List only of Immediate Caure (Final disease or condition resulting in death)	a. Due to (or as a consequer	מחט		ng, such as cardiac	or respiratory a	11651,		Interval Between Onset and Death Queeka
Departm	any inju		21. Signature 1F Ineral Service Licens	M	10		Park Dr.	Gaith		MD 2	20877 Approximate
it. Pages 1 and nument of Heelth	important: if liem 27 is marked any injury or other traumatic ev once.		William R. Lockhan 20a. Method of Disposition 1 Burial 2 X Cremation 3 F 4 Donation 15 Other (Specify)	20b. Plac cem	e of Dispo etery, cren	sition (Name of natory or other plants tan Crem	Ja:	Date n. 5,	20c. Location -	City or Tow	
2 should and Me	s mark raumati	2	19a. Informant's Name/Relationship (T)				and Number or Ru				Code) , MD 20877
and in the filed of the filed of the filed	ed other	0	17. Father's Name (First, Middle, Last) George Smith					e (First, Middle, Zimmer	Maiden Sumame	ə)	
Maryland 21213-0035 vd 2 should be filed within 72 hours after death with the Maryland thit and Mental Hyglene.	the Medical E	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. L	OO NOT use retired	during most of work		16b. Kind of Bu		ustry
J.S.D. irs after deal	Autologe III	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates:	11	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)		- America c, White, et Whi	tc.
h with th	at be no	<u> </u>	10e. Street and Number 407 Russell Aven	ue Apt. 207		10f. Zip Code 20877			United S	State	S
e Marylan	te beijing	_	Maryland Montgome	ry Gaith		ırg			10g. Citizen of W		1 XYes 2 ☐ No
Dire	ector	- ⊢	125-09-5044 Usual Residence of Decedent	M 201F 82	Yrs.		110010	Mar. 10	1921	[11in	ois d. Inside City Limits
Cur	neral		Wilson Health Car	7. Age (In yrs. last	birthday)	Gaither If Under 1 Year Months Days		8. Date of Birt (Month, Da	Montg		y nce (State or Foreign y)
Y.	Medic xamine		Edythe S. Ia. Fecility Name (If not institution, give			4b. City, Town, or	Location of Death	January	4c. County of	of Death	
Ph	nysicia		Decedent's Name (First, Middle, Last) Edythe S.	Lockhart				2. Date of Dea Month January	Day	Year 004	3. Time of Death 9:30 P ^M
		1	- State Registrar		Cer	tificate of l	Death		Reg. No.		10

	1 - For State C	of Maryland / Depa Cei	artment of Heal		giene Reg. No 2004	01583
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DONALD L. MCKELVEY 4a. Facility Name (If not institution, give street and not Memorial Hospital	umber)	4b. City, Town, or Loca Easton	2. Date of Di Month Januar tion of Death	Day Year	3. Time of Death 0700 M
Funeral Director	5. Social Security Number 280-26-8060 Usual Residence of Decedent	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year If Under 1 Yea	urs Min. 8. Date of Bi (Month, Di FEB 25	rth 9. Birth Co. 1933 OI	nplace (State or Foreign Intry)
ath with the Maryland 23s or 28s-f show ust be notified at	10a. State 10b. County MD TALBOT	10c. City, Town or Lo				10d. Inside City Limits XXYes 2 ☐ No
er dez Items	Armed F	2 ☐ No live		L c Origin? (Specify Yes or No xican, Puerto Rican, etc.)	10g. Citizen of What Col USA 14. Race - Amer Black, White Specify: WH]	ican Indian, , etc.
15- 15- 16- 16- 16- 16- 16- 16- 16- 16- 16- 16	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College 1 2 17. Father's Name (First, Middle, Last)	(Give (1-4or 5+)	dent's Usual Occupation kind of work done during DO NOT use retired) TMASTER	most of working Mother's Name (First, Middle	U.S. POSTAI	
Donald L. McKelve Baltimore, Maryland 212: permit, Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, tram once. To Be Comp	JOSEPH PETER MCKELVEY 19a. Informant's Name/Relationship (Type, Print) MARILYN L. MCKELVEY/WIF 20a. Method of Disposition	20b. Place of Dispo	AKER STREET,	MARTHA CHARL umber or Rural Route Numb EASTON, MD Date	er, City or Town, State, Z	
Donald Baltimore, permit, Pages 1 an Department of Heal Important: If lean any injury or other once.	1 Burial MXCremation 3 Removal from 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	CHESAPEAKI	2. Name and Address of F ELLOWS, HELE	CTR 1-8-2004 Facility FENBEIN & NEW SON ST EASTON	NAM FUNERAL	
1760, the be executed respine and sourial-transit real Examiner	Sequentially list conditions, if a my, locating to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events	caused the death. Do not ent	er the mode of dying, suc	ch as cardiac or respiratory a		Approximate Interval Between Onset and Death
of Vital Records, P.O. Box 68 Physician: The law requires that the death certifica rthis certificate has been signed by the attending pf rat director, page 2 should be detached for use as it	23b. Was decedent pregnant	gnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of deliment	very Day Year
Cords, P. wrequires that been signed b should be deta	Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause given in f		tobacco use contribute to Yes 2d No 3 ☐ Pro	the cause of death?
al Record The law requir cate has been s page 2 should Completed				1 ☐ Yes	prior to control death? 2.★No 1 Yes	opsy findings available ompletion of cause of
ivision or Attending ter death. irector: Afte n by the tune	27. Manner of Death 1 Natural 2 Accident 3 Suicide 28a. Date (Mo	Inpatient 2 EP/Outpatier e of Injury nth, Day Year) 28b. Time of Injury ce of Injury - At home, farm, str ding, etc. (Specify)	of 3 DOA Other: 4 of 28c. Injury at Work? M 1 Yes	2 □No		
he Hospita in 24 hours he Funeral pletely filled			vestigation, in my opinion	, death occurred at the time	, date and place, and due	to the cause(s)
Tot within com	29b. Signature and title of certifier 30. Name and address of person who completed car	use of death (Item 23a) (Type,		396Z	29d. Date signed (Month)	, Day, Year)
State Registrar	SCOTT D. FRIEDMAN M.D.	522 IDLEWILD Registrar's Signature		MD 21601		

			1-	For State Registrar		State of Ma	arylan	d / Depa <i>Ce</i> a	artment of rtificate of	Health ai <i>Death</i>	nd Mental H	lygier Reg. 1	- Em O O -2	0 1	584
	Physic	ian	1. [(First, Middle, Las			L	411-01	1-	2. Date of Month	Death		3. Time	of Death
1	/Medi	cal		THON		SAMUEL		(*)	47702		JAN	5	- 04		41 AM
	Examir				•	street and number)		4	4b. City, Town,				4c. County of Deal		
	Funeral			ocial Security Nu		X 7. Ag		ast birthday)	If Under 1 Year		4 Hrs. 8. Date of I	Birth	ITAZF		e or Foreign
	Director			224-72-8	3313 ¹⁽	XM 2□F	52	Yrs.	Months Days	Hours	Min. (Month, Feb.	Day, Yee 18,	1951	hplace (State puntry) Virgin	ia
	pur *		-	al Residence of I	Decedent 10b. County		10c City	, Town or Lo	anting						
	Aaryla F sho	ŏ		aryland	Cecil		Too. Oily	, rown or Lo		t Depos	oi t			10d. Inside	City Limits es 2⊠No
	28a-	rect		. Street and Num		·			10f. Zip Code	t bepor	SIL	10a (Citizen of What Co		
	h with	<u>e</u>	1	1379 Bel	videre Ro	ad				21904			U.S	•	
	ems 2	nera		Marital Status		12. Was Decedent Armed Forces?	Ever in U.S	S. 13.	Was Decedent of	Hispanic Origin	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ame	rican Indian,	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23e or 28e-f show other treumatic event, the Medical Evaminer must be notified at	d by Funeral Director	l .	1 Never Marrie		1 ☐ Yes 2 🕅 f If Yes, Give Year or Dates:			Tes, specify cuit		Puerto Alcari, etc.)		Specify: W	hite	
5	natu	ete		(Specit	15. Decedent's Edu fy only highest grad	ucation de <i>completed)</i>		16a. Deced (Give	lent's Usual Occu kind of work done DO NOT use retire	pation during most of	of working	16b. Y 0.1	Kind of Business/ck Buildi	Industry	oducts
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ary	2 should and Men is marke	Γ.			me/Relationship (T)	' ' '	7	19b. Mailir	g Address (Stree	and Number	or Rural Route Nurt	ber, City	or Town, State, Z	(ip Code)	
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Baltimore,	permit. Pages 1 a Department of Hee Importent: If item any injury or othe once.		20a	. Method of Dispo 1 D Burial 2 🛭		Removal from State	Ce	metery, cren	sition (Name of natory or other pla	1	Date		Location - City or		
Ę	mit. Pa bartmen sortent: injury		-		5 Other (Specify)		R.A		s & Co., I	1	01/07/04	Wes	t Chester,	Pennsy	lvania
Ва	permit. Pages Department of It Importent: If ite any injury or of			Thoma	TUD N.	Peteron.	5r.	Le Pe	rryville	terson Mary	& Son Fu land 219	03 - 0	1 Home,	P.A.	
ı				snock, or near	railure. List only o	lications that caused ne cause on each lin	the deeth	. Do not ent	er the mode of dy	ng, such as ca	ardiac or respiratory	arrest,		Approxim Interval B	etween
	Physician /Medical		dise	nediate Cause (F ease or condition ulting in death)	inal	a Acuio			ANY F	12TEN	LY DISC	= AS	9	Onset and	Death
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68760,	ificate be executed g physician and as the burial-transit	edical				d	_								
	≝ on e			EMALE:		23c. If yes, outcome	of prognan	101							
. Box	death cert e attendin id for use a	Physician/M	23b	 Was decedent in the past 12 π 1 □ Yes 2 □ 	nonths?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3 □	Ectopic pregnand Other (specify)	у			23d. Date of deli- Month	very Da y	Year
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Division of Vital Records,	law requires that the death cert as been signed by the attendin 2 should be detached for use	þ	Part	II. Other signific	cant conditions co	ntributing to death bu	ut not resul	Iting in the ur	derlying cause gr	ven in Part I.			use contribute to		
ecc	ne law re has be ge 2 sho	Completed									24a. Wa	s an	24b. Were aut	opsy findings ompletion of	s available
= =	ate pag	Com										formed?	death?	2[340	04436 01
Vita	Physicien: Th r this certificate ral director, pag	Be		Was case referre examiner?	-	Janaital:					Death (Check only				
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o	ding th. : After fune	tlon		1 Natural 2 Accident	5 Pending investigation	(Month, Day	Year)	Injury	28c. Inju Wo M 1	yat rk? Yes 2.⊟No	28d. Describe	now inju	ury occurred		
<u>isi</u>	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;		3 🗍 Suicide 4 📋 Homicide	6 Could not be determined	28e. Place of Inju	ury - At hon c. (Specify)	ne, farm, stre					ind Number or Rui te)	al Route Nui	mber,
	Hospitel of the Hours all Funerel Desired in Funerel Desired in Stell of the Hours and the Hours are		29a	. Certifier 1	□ Certifying Phy	sicien: To the best of	of my know	rledge, death	occurred at the ti	me, date and p	place, and due to the	e cause(s	s) and manner as	stated.	
	To the Ho within 24 t To the Fu completely	Medical	aah	one)	Medicel Exemi	ner: On the basis of and manner sta	examination	on and/or inv	estigation, in my o	pinion, death	occurred at the time	, date an	nd place, and due	to the cause((s)
	S S S	-	290	. Signature and ti	ria oi carrula	1	_	`	29c. Licens		,		ate signed (Month,		
7	E /		30 1	Name and address	ss of person who are	empleted cause of de		23a) (Type 6		21809		74	m 5-16 2	504	
	1			5 PNA						Timo	NOM -	25	21093		
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	Registr	ar			Sull O S	2004 Augustra	NELED S	al for	and the						

Thomas MAYTON

Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10b. Street and Number 10f. Zip Code 10g. Citizen of What County 11g. Was Decedent Ever in U.S. Armed Forces? 11	an Indian, etc.
Physician Medical Examiner Aa Facility Name (If not institution, give street and number) Ab. City, Town, or Location of Death Ac. Country of Death Ac.	lace (State or Foreign try) Od. Inside City Limits 1 Yes 2 No try? an Indian, etc.
Funeral Director Social Security Number 6. Sex 7. Age (in yrs. last birthday) If Under 1 year If Under 24 Hrs. 8. Date of Birth 9. Birthple	Od. Inside City Limits 1 Yes 2 No try? an Indian, etc.
To complete the state of the st	1 Yes 2 No try? an Indian, etc.
106. Street and Number 107. Zip Code 108. Street and Number 109. Citizen of What Count 119. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 15. Decedent's Usual Occupation (Give kind of work done during most of working (Give kind of work done during most of working (Give kind of work done during most of working (Give ki	an Indian, etc.
11. Marital Status 1 Never Married 2 Married 1 Never Married 1 Nev	dustry
15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 16. Kind of Business/Ind (Give kind of work done during most of working life. DO NOT use retired) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)	
18. Mother's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)	
William D. Hindman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zipe)	Contai
17. Father's Name (First, Middle, Last) William D. Hindman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip William C. M. Master Jr. William C. M. Master Jr. Hog nhoutstract 86, 9080 Beer Veide Bo	elgium
E 3 5 1 Definal 2 Cremation 3 Removal from State New London Presbyterian Church Cennelery New London Presbyterian Church Cennelery	on, PA
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	Approximate Interval Between Onset and Death
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edicate be difficate be gaphysicia as the burn as the	
O 2 5 5 No 9 □ Unknown 9 □ Unknown 5 □ Other (specify)	ny Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the 1 yes 2X No 3 probations and 24b. Were autop	ably 4 Unknown
To be do not see that the second of the seco	psy findings available inpletion of cause of
The state of the s	()
The state of the s	
2	
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and titlabor certifier 29c. License number 29d. Date signed (Month, D.	
29b. Signature and titla of certifier 29c. License number 1 - 0058419 29d. Date signed (Month, Co	4.1
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1
State State Registrar AN 0.7 2004 State Registrar	

DHMH 17 Rev 1/2001

Registrar

			•	pe or Print in B State of Maryland	d / Depa	rtment		Mental Hyg	_	01587
ľ	Physicia		1. Decedent's Name (First, Middle, Last) ALICE P. MAJORS					2. Date of Deat Month		3. Time of Death
	/Medic Examin	er	4a. Facility Name (If not institution, give stre		conte	,	own, or Location of Deal	h	4c. County of De	
ŧ	Funeral Director		NUNINSULA NUS INNA 5. Social Security Number 6. Sex 213-14-1527 1□ N	7. Age (In yrs. I.		If Under 1		8. Date of Birth	9. Bi	irthplace (State or Foreign Country) LISBURY
	Aaryland	ō	Usuel Residence of Decedent 10a. State 10b. County MD WICOMIC		, Town or Loc					10d. Inside City Limits 1¼□Yes 2□No
	sa of 28a-	i Director	10e. Street and Number 931 E. CHURCH STREE			10f. Zip (304	1	0g. Citizen of What C	Country?
336	72 hours after death with the Maryland netural; or Itams 23e or 28e-1 show dical Examinar must be motified at	by Funeral		. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decede Yes, specif	ent of Hispanic Origin? (S fy Cuban, Mexican, Puer No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Arr Black, Wh Specify: W	nite, etc.
21215-0036	C 1 3	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion completed) College (1-4or 5+)	16a. Deced (Give life. L HOMEM	kind of work DO NOT use	Occupation done during most of wo a retired)	orking	16b. Kind of Busines	s/Industry
	be filed tal Hyg d other event,	Be	12 17. Father's Name (First, Middle, Last) RAYMOND J. PARSONS		HOMEM	AKEK	18. Mother's Na	me (First, Middle, M		
Maryland	s 1 and 2 should be f Health and Menta item 27 is marked other traumatic ev	J.	19a. Informant's Name/Relationship (Type WILLIAM J. MAJORS, J			•	(Street and Number or R			
Baltimore,			20a. Method of Disposition 1 □ Surial 2 □ Cremation 3 □ Rer 4 □ Donation 5 □ Other (Specify)	20b. P	lace of Dispo- emetery, cren	sition (Nam- natory or oth	e of her place)	Date	20c. Location - City of	
Baltir	permit. Page Department o Importent: If any injury or once.		21. /gnature Funeral Service Licensea	Kell	22	. Name and	Address of Facility BO			INC. YLAND 21804
	Pnysician		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition	tions that caused the deat cause or each line.	. Do not enti	er the mode		c or respiratory arri		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	2/2					4707
3760,	ate be executed nysician and he burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (of as a consequ	2 /2	227	in			4-4-
P.O. Box 687	The law requires that the death certificate to the same signed by the attending physicage 2 should be detached for use as the total.	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	b. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of di 9 □ Unknown	I death 3	Ectopic pre			23d. Date of d Month	lelivery Day Year
	luires that the death n signed by the atte ald be detached for		Part II. Other significant conditions contri	ibuting to death but not resi	ulting in the u	nderlying ca	use given in Part I,			to the cause of death? Probably 4 □Unknown
Records,		Completed						24a. Was a autops perform	y prior to	
Vital	icien; certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Ho	spital: 1 Inpatient 2	EB/Outpaties	nt 3 DO	Othor	eath (Check only on	ence 6 Other (Sp	nacify)
of	fing After fune	ation: To	27. Manner gl-Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		3c. Injury at Work? 1 Yes 2 No		ow injury occurred	Carry
Division	i Lite	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specifical Control of the Control of	ome, farm, str	eet, factory	office	28f. Location (St City or Town	treet and Number or I n, State)	Rural Route Number,
	o the Hospital of the Funeral of the Funeral ompletely filled	edical		cian: To the best of my kno or: On the basis of examina and manner stated.						
7	To the	Me	29b. Signature and title of certifier	AP			License number	0	9d. Date signed (Mon	***
4	m		30. Name and address of person who som	applied cause of death (Item	n 23a) (Type,	Print)	2534 MANOIL ST WOOKS	· SALI	soling M.	25
	St Regist	ate	31. Date filed (Month, Day, Year) 5 20	32. Registrar's Signa	ature &	Sp	oaks			

		riease i		it in Black in					:
		1 _ For	State of Ma	aryland / Depa			<i>l</i> lental Hygi	ene	. 01500
		Registrar		Cei	tificate of	Death	Re	g. No U U	+ 01388
Dhusis		Decedent's Name (First, Middle, Last,)				2. Date of Death Month	Day Yee	3. Time of Death
Physici /Medi		JAMES		McCAFFF	EY		JANUARY	3 200	
Examir		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		4c. County of D	aeth
		ATLANTIC GENERAL	HOSPITAL		BERL	IN		WORCE	ESTER
Funeral		5. Social Security Number 6. Sec	x 7. Ag M 2 ☐ F	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. E	Birthplace (State or Foreign Country) NEW YORK
Director		053-24-2364	M ZUF	73 Yrs.			FEB. 2,	1930	NEW YORK
pud *		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	cation				10d. Inside City Limits
laryle eho	5	DELAWARE SUSSEX		SELBYV					1 Yes 20 No
Z8a-f	Director	10e. Street and Number		U.S. DELET .			1 10	- Cities - 4 Mary - 4	
with			7.TD		10f. Zip Code 1997	E	10	g. Citizen of What USA	Country?
death with the Maryland me 23a or 28s-f ehow (must be notified at	Funerai	33 YOLANDA STREE	12. Was D <i>ec</i> edent	Ever in U.S. 13.1			acty Yes or No-		merican Indian,
ter d	두	1 Never Married 2 Married	Armed Forces?	No.		dispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, W	
1215-0036 within 72 hours after ene. he Micdical Examine	þ	3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ I If Yes, Give Year or Dates:	1947-49	1 □ Yes 2 No	Specity:		Specify:	WHITE
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21215-0036 d within 72 hours af giene. than 'natural', or the Medical Exemple.	Completed	12	Conego (1 voi c		SAND HOG		-	PUBLIC	UTILITIES
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aryland should be file and Mental Hy is marked oth	To E	TERRENCE	McCAFFRI	ΞY		ANNE	1	McDONNELI	
laryland 2 2 should be filed 2 should be filed and Mental Hygi		19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailir	g Address (Street	and Number or Rur	al Route Number,	City or Town, State	, Zip Code)
2 P = 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		EILEEN McCAFFREY/V	VIFE	33 Y	OLANDA S	TREET, SE	LBYVILLE	, DELAWAF	E 19975
or the rest of the		20a. Method of Disposition 1 № Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other plac	ce)	Date 20	Oc. Location - City	or Town, State
Baltimore, Bartimore, Dermit. Pages 1a Important if licen any injury or othe		'4 □Donation 5 □Other (Specify)	Comovar from State	GATE OF I	IEAVEN	1/7/	04	DAGSBORO	, DELAWARE
Don Balti Permit. Departit Importa any inju		21. Signature Filneral Service Licena	3/ 1	22	. Name and Addres	ss of Facility			
		1 Leuly W-	Hart	HA	STINGS F	UNERAL HO	ME, SELB	YVILLE, I	E. 19975
		23a. Pakt Enter the disease, or compleshock, or heart failure. List only or	ications that dauged ne cause on each lin	the death. Do not entine.	er the mode of dyin	ng, such as cardiac	or respiratory arres	it,	Approximate Interval Between
Pnysician		Immediate Cause (Final disease or condition	0.19	0					Onset and Death
/Medical		resulting in death)	Due to (or as	a consequence of):					
Examiner		Sequentially list conditions	ASU	WP.					
4 6-	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):					
ocute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	>						V
3-24- 2/2// 760, te be executed system and the burnat-transit		resolurig in dealin) cast	Due to (or as	a consequence of):					
6876 A Carlifficate be rafficate be as the bu	dical		1						
OS 68 Ox 68 certificat	Physician/Medi	IF FEMALE:		,	· · · · · · · · · · · · · · · · · · ·				
Box death cert estanding of for use	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1☐Live birth	2 Fetal death 3	Ectopic pregnancy	,		23d. Date of d	lelivery Day Year
O. I of the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5	Other (specify)				
CSS DAMES DIG CORDS POR SON W requires that the death certificat been signed by the attending phy should be detached for use as the		Part II. Other significant conditions cor	stributing to death by	at not resulting in the ur	iderwing cause give	an in Part I	23a Did toha	cco use contribute	to the cause of death?
ords, P. requires that the signed by nould be detacted.	i by	Takin and algument and an analysis	moduling to doduino	at the troubling at the di	denying cadso giv	GILLI.			Probably 4 Minknown
ecord law requir	Completed						-		
Rec Haw Has b	Idu						24a. Was an autopsy	prior to	autopsy findings available of completion of cause of
r. Th	Ö						performe 1 ☐ Yes 2	ed? death' I No 1 □ Ye	es 2 No
of Vital Physician: This certifica	Be	25. Was case referred to medical examiner?	lospital:		Oth		Check only one		
Of Phys	P	1 Yes 2 No	1 Inpatie	nt 2 ER/Outpatien		4 LI Nursing Ho	me 5 Residen		ecify)
Juner Funer	io	1 Natural 5 Pending	(Month, Da)	y Year) 28b. Time of Injury	28c. Injury Work	y at k? Yes 2 □ No	28d. Describe how	injury occurred	4
isic death death the	icat	2 Accident investigation 3 Suicide 6 Could not be	28a Place of Inju	ury - At home, farm, stre			28f Location /Stm	at and Mumbas as	Pural Pouta Number
Division of or Attending after death of the funs of the function of the functi	Certification:	4 ☐ Homicide determined	building, etc	c. (Specify)	et, ractory, office		City or Town,		Rural Route Number,
Division of Vital Recuit to the Hospital or Attending Physician: The law within 24 hours after death within 24 hours after death. The the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2 sempletely filled in by the funeral director, page 2.		25a. Contilior 1 N Certifying Phys	sician, To the heat.	d my knowledge, death	ucamped at the time	ne. date and da	and due to the	earer and man	ac chilar.
Hos 24 h Fur etely	edical	(Check only 2 Medical Examinations)	ner: On the basis of and manner sta	examination and/or inv	estigation, in my of	pinion, death occurr	ed at the time, date	and place, and di	ue to the cause(s)
vithin o the	Me	29b. Signature and title of certifier			29c. License	e number	290	. Date signed (Moi	nth, Day, Year)
		610 1/101			100	3912		1/4/	i UI
Comp		30. Name and a dress of person who co	mpleted cause of de	eath (Item 23a) (Type		11/2		1/7/6	-6
O VA		DENNIS CHODNICK				RLIN. MD	21811	(CS)	1
Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	/	,			
Registr		JAN 0 6 20	104 Se-	eva &	Spark	2			

MELVIN HENRY

MILLER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1

			1 = State Registrar		,	Certi	ficate of	Death			Reg. 1	No.	UH	0138
			1. Decedent's Name (First, Middle, L.	ast)						2. Date of D	eath	Day	V. S.	3. Time of Death
	Physici /Medio		Melvin Henry M	liller						JANU			Year 2004	1715
	Examir		4a. Facility Name (If not institution, gi			4	b. City, Town, o		of Death			4c. Count	y of Death	
			THE MEMOR		SPITA		EAS					TAL	B07	
	Funeral			1177 M 2□ F	e (In yrs. last bi	N. A.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D	irth Day, Yea			place (State or Foreign
i.	Director	ļ	215-05-1286 Usual Residence of Decedent	A - 8	33	Yrs.		J		March .	14,1	920	Mary	land
	land ow		10a. State 10b. County	· · · · · · · · · · · · · · · · · · ·	10c. City, Tow	n or Loca	tion						1	10d. Inside City Limit
	Mary -f sh	ō	Many land Careld		D +									1 ☐ Yes 2√2 N
	28a	Director	Maryland Caroli 10e. Street and Number	ne	Denton		10f. Zip Code				10a. C	Citizen of	What Cour	
	death with the Maryland ms 23a or 28a-f show ficural be rectified at		280 Camp Rd Homes	tead Manor	Rm 213		2162	a				U.S.		,
	death ms 2	Funeral	11. Marital Status	12. Was Decedent I		13. Wa	s Decedent of H	lispanic Ori	igin? (Spe	ecify Yes or N	0-	14. Ra	ce - Americ	can Indian,
0	or its		1 X Never Married 2 ☐ Married	Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give	№ 1943-		es, specify Cuba			Rican, etc.)			ck, White,	
0000	ral',	d by	3 Widowed 4 Divorced	Year or Dates:	1947	11	Yes 2∏ No	Specify:				Specif	y: Whi	_te
5	be filed within 72 hours after death with the Marylan ital Hygiene. of other than "natural", or itams 23s or 28s-f show event, its Macinal Exemiter forest by nuffled at	Completed	15. Decedent's E (Specify only highest gi		16a	. Deceder	nt's Usual Occup	ation during mos	t of worki	na	16b.	Kind of B	usiness/In	dustry
Z	Mithin Nen.	I di	Elementary/Secondary (0-12)	College (1-4or 5			NOT use retired	,		•				
7	iled v Hygie ther t		8 17. Father's Name (First, Middle, Las	*	С	hiei	warehou					vernn		
	ould be filed within Mental Hygiene. Arked other than atic event, I.a.M.	Be	John Miller	9						(First, Middle o11man		en Sumar	ne)	
Ž	should be filed within nd Mental Hygiene marked other than umatic event, ILe M.	2	19a. Informant's Name/Relationship	(Tuna Print)	101	Maiting	Adda /Ca							
Z	d 2 stranger						Address (Street							Code)
נו	1 and Health em 27 ther tr		Helen C. Poole 20a. Method of Disposition	sister			easant	St Z		rhills	-		City or To	own State
2	Pages nent of I int: If Its iry or o		1 X Burial 2 ☐ Cremation 3 [14 ☐ Donation 5 ☐ Other (Special		Easter	ry, cremat n Sho	ory`or other plac ore	1					•	
Dairmin			21. Signature of Funeral Service Lice		Vetera		netery lame and Addres			/2004	Hui	rlock	, Mai	cyland
Ď	permit. Departr Importa eny inju		1 /A 16	-		Fle	egle an	d Hel	fenb	ein Fu	nera	al Ho	me PA	A
	- 2		23a. Part1. Enter the disease, or con	plications that caused	the death. Do	not enter t	he mode of dyin	g, such as	cardiac o	oro, M	ary.	land	216:	Approximate
	Physician		Immediate Cause (Final	One cause on each im	16.									Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as	a consequence	of):	al fa	11000					_	
	Examiner		ray, was an area of the second	0	telygos	atte	m							
Z		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence									
	cuted nd ransii	Examiner	that initiated events	c	_ /									
5	e exe ian a urial-t		resulting in death) Last	Due to (or as a	a consequence	of):								
	stificate be executed ing physician and e as the burial-transit	Medical		d										
5	entific ling p	Mec	IF FEMALE:										I	
2	ath contract	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of Live birth	2 Fetal death		topic pregnancy					23d. Da Mo	te of delive	ry Day Year
	the a	Physiclan	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 🗌 O	ther (specify)					1910	••••	Day 15a1
•	that til ed by detac	Ph	Part II. Other significant conditions	contributing to death bu	ıt not resulting i	n lhe unde	rlying cause give	en in Part I		23e Did	tobacco	use cont	ribute to th	e cause of death?
5	sign d be	d by		schemic	_		,,,,,g					2 🗆 No	3 Prob	
Ş	v requ	Completed	Lower go.	strongertect	rne 1 b	1000								
	has ge 2	E C	male	21.000/101						24a. Was			were autor prior to con leath?	osy findings available apletion of cause of
5	n: Th	e Co	25. Was case referred to medical	101						1 Yes	2 N			2 🗆 No
>	sicia cert irecte	00	examiner?	Hospital:	nt 2 ER/Ou	de attact	3 DOA Othe			(Check only				
5	Phy ar this aral d	J: To	27. Manner of Death	28a. Date of Injur (Month, Day		Time of	3 DOA 28c. Injury	4 🗆 140	7.0	ne 5 Resi)
5	nding th. :: Afte	ig le	1 ØNatural 5 ☐ Pending 2 ☐ Accident investigation		Year)	njury		(? Yes 2 ☐ I	1		,	,		
2	Atte ecto by th	ific	3 Suicide 6 Could not be determined	28e. Place of Inju	ry - Al home, fa	rm, street,	factory, office		2				er or Rurai	l Route Number,
5	s after selection of the selection of th	Certification:	4 - Homode	building, etc	. (Зресну)					City or To	wn, Stai	te)		
	ospit hour unere		29a. Certifier 1 Certifying Pr (Check only 2 Medical Exam	nysician: To the best of	f my knowledge	, death oc	curred at the tim	e, date and	d place, a	nd due to the	cause(s) and ma	nner as sta	ated.
	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical	570	miner: On the basis of and manner stat	ted.	wor invest			n occurre	d at the time,	date an	nd place, a	and due to	the cause(s)
	To To COUR	Σ	29b. Signature and title of certifier	/	12		29c. License				29d. Da		(Month, E	
		ļ	> Harou Laura	Jin Vi			0	5548	54			/-	9-	2004
			30. Name and address of person who				*							
			Haiou Laura Jin 31. Date filed (Month, Day, Year)	219 5	S. Wash: r's Signature	ingto	n St	Easto	n, M	aryland	d 2	1601		
	Sta Registra		JAN 12	2004	Curs Di	1	Call)							
				1		Martin San	Challen .							

DHMH 17 Rev 1/2001

			State of Maryla				•		_		
		1 - For Stete Registrar	oraro or maryra			of Death	Montain	Reg. No	200	4 01	590
Physic	ion	1. Decedent's Name (First, Middle, Last)				2. Date of De			3. Time o	f Death
Physic /Med Exam	ical	John Daniel McMas 4a. Facility Name (If not institution, give			4b. City, 7	own, or Location of Dea	January	10	2004 County of Dea	838	P M
		Anne Arundel Medic	cal Center		Annap	olis		Ar	ne Aru	ndel	
Funera		5. Social Security Number 6. Se	ŪM 2□F	s. last birthday, Yrs.		Year If Under 24 Hr Days Hours Mir	. (Month, Di	ıy, Year)		rthplece (State ountry)	
Director	4	179-24-6445 Usuel Residence of Decedent	71				June 4,	1932	Peni	nsylvan:	ia
ryland		10a. State 10b. County	10c. 0	City, Town or L	ocation					10d. Inside C	
he Ma	Director	Maryland Anne Arur	idel Ann	apolis							2 🗌 No
with ti	Ö	10e. Street and Number			10f. Zip (izen of What C		
death with the Maryland ime 23s or 28s-f show froust be notified at	Funeral	1221 Madison Stree	12. Was Decedent Ever in	U.S. 13.	Was Decede	ent of Hispanic Origin? (Specify Yes or No		ed Stat	erican Indian,	
je 22 2	by Fur	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☑ Yes 2 □ No 19 If Yes, Give Year or Dates: 10	50-	If Yes, specif	ly Cuban, Mexican, Pue	rto Rićan, etc.)		Black, Whi		
Maryland Z1Z15-0030 d 2 should be filed within 72 hours after th and Mental Hygiene. 77 Is marked other then "naturel", or lite traumatic event, the Medical Examins	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual kind of work DO NOT use	done during most of w	orking	16b. Ki	nd of Business	/Industry	
d with	mo:	Elementary/Secondary (0-12)	College (1-4or 5+)			Engineer		Defe	nse Cor	tracto	r
be filed that Hygis d other	Be	17. Father's Name (First, Middle, Last)					ıme (First, Middle			i Li ac Ly	
arylan should be ind Mental in marked o umatic eve	2	Edward McMaster				Pearl D	- /				
re, Maryla s 1 and 2 should f Health and Men item 27 is marks other traumatic	1	19a. Informant's Name/Relationship (T) Kimberly Heskett /				Street and Number or F Tree Drive					1060
is 1 and 2 of Health ar item 27 is		20a. Method of Disposition		Place of Dispo	osition (Name	e of	Date D		e, Mary	land 21	1000
Pages Bent of nt: H i		1 ☑ Burial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)		cometery, cres 11cres t	•		/2004	Anna		Marylan	٠.
Dallinore, permit. Pages 1 and Department of Healingcreant: If item 2 and righty or other once.		21. Signature of Funeral Service Coens	1	22	2. Name and	Address of Facility J	ohn M. T	ay1o	r Funer	al Home	e, Inc
		23a. Part1. Enter the disease, or complishock, or heart failure. List only of		ath. Do not ent	ter the mode		ester St ic or respiratory a	. An	napolie	Approximate Interval Bette Onset and I	e ween
Pnysician /Medical		disease or condition resulting in death)	a. Congest Due to (or as a conse		ert Fa	ilure				4 year	s
Examiner			b. Pulmona	5-995 (1900)540	rtens	ion				4 year	-
₽ #	iner	Sequentially list conditions, lary leading to increase cause. Enter Underlying	Directo (or as a conse	equence of):						1 Juli	
ate be executed sysician and he burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	acuence of).							
le be ex sician a	cai E		200 10 (0) 23 2 001190	squerice (i).							
ifficate g phys			3.								WILLIAM A
box conficate leath certificate attending phy:	M/W	230. Was decedent pregnant	23c. If yes, outcome of pregi 1☐Live birth 2☐Fe		∃Ectopic pred	ND 2 D C V		2	3d. Date of de	ivery	
the charge	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time of 9 Unknown		Other (spec				Month	Day Y	rear
gned b	by P	Part II. Other significant conditions col	ntributing to death but not re	sulting in the u	nderlying cau	ise given in Part I.	23e. Did t	bacco u	se contribute to	the cause of d	eath?
w require been si								es 2	□No 3□Pr	obably 4 🗆 U	Inknown
he law requires the has been signed as should be come.	Completed						24a. Was autop	sy	prior to	topsy findings a	available ause of
							1 Tes	2220	death? 1 ☐ Yes	2□ No	
ysician: T ysician: T is certificat director, pa	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: Inpatient 2[☐ ER/Outpatien	+ 2□ DOA	Out	ath <i>(Check only o</i> Home 5 ☐ Resid	100	T0::		
g Physicar this neral dia	H-	27. Manner of Ceath	28a. Date of Injury (Month, Day Year)	28b. Time of		Injury at Work?	28d. Describe h			city)	
uttending I death. ctor: After y the funer	atio	1 Natural 5 Pending investigation	(Month, Day roar)	Injury	М	1 ☐ Yes 2 ☐ No					
Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certificately filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, str cify)	eet, factory, o	office	28f. Location (S City or Tox	itreet and m, State)	Number or Ru	iral Route Numb	ber,
To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	Medical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my kn ner: On the basis of examin and manner stated.	nowledge, death nation and/or inv	n occurred at vestigation, in	the time, date and place my opinion, death occ	e, and due to the ourred at the time,	ause(s)	and manner as place, and due	stated. to the cause(s)	1
To the within 2 To the complex	Me	29b. Signature and title of certified	1		29c. l	icense number		29d. Date	signed (Monti	n, Day, Year)	
		* X Lel	only	~	Ĩ	21983	8	il	11/20	104	
		30. Name and address of person who co	impleted cause of death (Ite	em 23a) (Type,	Print)		,				
	ate	Stuart E. Seloni 31. Date filed (Month, Day, Year)	32. Restrar's Sign		e Road	Annapolis	, MD 214	01			
St. Regist	ate ra r	A MANAGE TALL TO SEE	004		Gard 1						

			1 - For State Registrar	State of M	1arylan		artment of H			giene 20	04	0	591
-	- · ·		1. Decedent's Name (First, Middle, I	.ast)					2. Date of De		Year	3. Time of	Death
	Physicia	100	Charles	G. Me	ador	Jr	•		January	$y = 10^{3}$, 200)4	8:30	P^M
	/Medic Examin	_	4a. Facility Name (If not institution, g	ive street and number	r)		4b. City, Town, o	or Location of Dea	th	4c. County of	f Death		
		%'	12619 Buckingham	n Drive			Bowie	9		Prince	e Geo	orges	
	Funeral		Social Security Number 6.		ge (In yrs. I	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th v. Year)	9. Birthp	lace (State o	r Foreign
	Director		225-38-4060	X☐M 2☐F	68	Yrs.	thorning Days		April 1	16, 1935	Virg	ginia	
	p ,		Usual Residence of Decedent 10a, State 10b, County		10c Cib	y, Town or Lo	cation				1	0d. Inside Cit	ty Limits
	larylan ahow	'n			100.01						'	1 📉 Yes	*
	Ba-f	Director	MD Prince 10e. Street and Number	Georges		Bowi	e 10f. Zip Code			10g. Citizen of W	hat Cour	tn/2	
	a or			om Drivo			207	15		USA	nat oour	, .	
	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or items 23a or 28a-f ahow other than "natural", or items 23a or 28a-f ahow avant. The Medical Examana must be notified a	Funeral	12619 Buckingh	12. Was Deceden	t Ever in U	S 13 1	1		Specify Yes or No		- Americ	an Indian.	
_	item item	S	1 Never Married 2 Married	Armed Forces	?	J. 10.	Was Decedent of H f Yes, specify Cub	an, Mexican, Pue	rto Rican, etc.)	Black	, White,		
<u> </u>	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates		62	1☐ Yes 2☐XNo	Specify:		Specify:	Whi	Lte	
9500-6121	filed within 72 hours after Hygiene. other then "natural", or ite ant, the Medical Examble.	Completed	15. Decedent's	Education		16a. Dece	dent's Usual Occur	pation		16b. Kind of Bus	iness/Inc	lustry	
212	nin 7:	ple	(Specify only highest of Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	kind of work done DO NOT use retire	during most of wo	orking				
7	d with	шо	12		0.7	P	lumber			Plumber	Loc	al #5	
פ	othe vant,	ВеС	17. Father's Name (First, Middle, La							Maiden Sumame)		
Maryland 2	Aenta Aenta rked	ToE	Charlie G. Mea	dor, Sr.				Mary 1	Foster				
a	and 2 should be filled wi salth and Mental Hygien n 27 is marked other th er traumatic evant, the	i l	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street	and Number or A	lural Route Numbe	er, City or Town, S	itate, Zip	Code)	
Σ	and 2 ealth n 27 i		Mary Lou Meador	/ Wife			9 Bucking	gham Driv		e, MD 20	715		
ore C	-ISE		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	□Ramoval from Stat		lace of Dispo emetery, crer	sition (Name of natory or other pla	ce)	Date	20c. Location - C	city or To	wn, State	
Ĕ	Pages nent of ant: if it		'4 □Donation 5 □Other (Spe		MD		ans Cemet			Crowns		-	
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lic	ensee		22	Name and Address Anna	ess of Facility Ro	obert E.	Evans Fu vie, MD	nera 2071		е
P.O. Box 68760,	The law requires that the death certificate be executed we want to the has been signed by the attending physician and wigher to a see as the burial-transit and the second of the second	by Physiclan/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions	c	e of pregna 2 Fetal at time of de	uence of): incy I death 3 [seath 5 [er the mode of dying Cerk (Cerk (Cer	y N	A	23d. Date Mont obacco use contrib	of delive	Day Y	eath?
Division of Vital Records,	w require been si should?	Completed	17410010	nath							7		
ဝ	alaw has b	du	17×1000	"lacal	ni				24a. Was	osy pr	ior to con	osy findings a apletion of ca	available ause of
<u> </u>		ပ္ပ							1 ☐ Yes		ath? ☐ Yes	2□ No	
/ita	ysician: The lav is certificate has director, page 2	Be	25. Was case referred to medical examiner?	Magaitab			0,4		ath (Check only o				
	this c	ဥ	1 ☐ Yes 2 💢 No	Hospital: 1 Inpa		ER/Outpatier	I SU DON	1er: 4 ☐ Nursing		dence 6 Other)	
בַ	ding Ph h. After th funeral	on:	27. Manner of Death 1	28a. Date of In (Month, D	jury Day Year)	28b. Time of Injury	Wo	rk?	28d. Describe i	now injury occurre	đ		
Sio	Attendi death. ctor: A y the fu	cat	2 Accident investigat 3 Suicide 6 Could no	he -				Yes 2 □No	224 1 1 1				
<u> </u>	i or Attendater deatl Director: In by the	Certification;	4 Homicide determine	ad 289. Place of I	njury - At no etc. <i>(Specif</i>)	ome, tarm, str v)	eet, factory, office		City or Tox	Street and Number vn, State)	or Hura	House wuma	<i>)</i> 9 <i>r</i> ,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific; completely filled in by the funeral director.		200 Cartifice 10 Cartifician	Physician: Tathaha	at of much or -	wlodge de-	a conversed at the co	ma data and als-	o and due to the		BOS 5 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	atod	
	Hos. 24 ho Funk tely (edical		Physician: To the bes aminer: On the basis and manner:	of examinat								i
	o the ithin (o the	Mec	29b. Signature and title of certifier	1 // 17	/		29c. Licens	se number		29d. Date signed	(Month, I	Dey, Year)	
	F 3 F 8		11.A.	Mala	1,1	7.0	DO	012	85	1.12.	04	1	
			20 Name and address of	o completed assure	dooth /lto-	2321/7	Print		, ,	01			
			////	MOLAVI	. MD		29c. Licens 00	end ove.	Rd C	heverly	10	20	785
	Sta Registi		31. Date filed (Month, Day, Year)	32. Regis	trar's Signa	ture	1 10						

ORIGINAL

		•	For State Registrar	State	of Marylar		artment of <i>tificate o</i>		and Mei		jiene leg. No.	2004	01592
- N	the gr		Decedent's Name (First, Middle, L.	ast)					2.	Date of Dea Month		Voor	3. Time of Death
	Physicia		Joseph Gerard	McMat	on				J	anuary	Day 9	Year 2004	12:15 A ^M
	/Medic Examin	_	4a. Facility Name (If not institution, gi				4b. City, Town	n, or Location o		andar j		County of Death	
	Examin	er			,		Can	ofton			Λ.	nno A.	
.03	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		1628 Angus Cour 5. Social Security Number 6.	Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye	ofton ar if Under 2	24 Hrs. 8.	Date of Birth	1	nne Art	nplace (State or Foreign untry)
	Funeral		· ·	1 ∑ M 2□F	69	Yrs.	Months Day	ys Hours	Min.	(Month, Day uly 17	, Year) 103	/ Nov	Vork,NY
1 1 TO	Director	-	051-26-5869 Usual Residence of Decedent						J	ury 17	, 173	4 New	/ IOIK,NI
	and		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
	eho	5	MD Anne Ar			Croft							1 X Yes 2 ☐ No
	Ne N	Director	10e, Street and Number	under		Crort	10f. Zip Cod				toa Citiz	en of What Co	untry?
	ith t	늅					TOI. ZIP COU	8			rog. Oniz	on or writer co	urity:
	4 within 72 hours after death with the Maryland Jion Han natural; or Items 23a or 28a-f ehow Ite Madical Examinar must be nutified at	Funeral	1628 Angus Cour					114				USA	1
	ems err	Ine	11. Marital Status	12. Was De	cedent Ever in U Forces?	.S. 13.	Was Decedent of Yes, specify C	of Hispanic Orig Suban, Mexican	gin? (Specif i, Puerto Ric	y Yes or No- an, etc.)	1	 Race - Amer Black, White 	
٥	or it		1 ☐ Never Married 2 🔀 Married	If Yes. C	2 □ No Bive		1□Yes 2∰	No Specify:				Specify: W	Thite
ຊິ	ral',	d by	3 Widowed 4 Divorced	Year or	Dates: 156-								
3-UU36	72 h natu	Completed	15. Decedent's l (Specify only highest g	Education rade completed	d)	16a. Dece	dent's Usual Oc kind of work do	cupation one during most	t of working		16b. Kin	d of Business/I	ndustry
V	thin a s	چّ	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use re	tired)	_				
Z		no.			5+	Sal.	es Manag	ger				Hotel_	
0	be filed ntal Hygid of other event, I	0	17. Father's Name (First, Middle, Las	(t)				18. Mothe	r's Name (F	irst, Middle.	Maiden S	Sumame)	
and	ld be lental ked o ic eve	To B	Joseph Gerald	McMahor	ı, Sr.			Agn	es Ca	arroll			
<u> </u>	should nd Men marke umatic		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Str	eet and Numbe	or or Rural R	Route Numbe	r, City or	Town, State, Z	ip Code)
Z	d 2 ith a tract		Katherine E. McM	lahon/ W	Vife	1628	3 Angus	Court	Crof	ton, M	D 2	1114	
	1 and Health em 27 ther to		20a, Method of Disposition		20b.	Place of Dispo	sition (Name of		Date	9	20c. Loc	ation - City or	Town, State
ō	Pages nent of h int: If its iry or o		1 ☐ Burial 2 X Cremation 3		n State		natory or other	place)	1/10/2	2004		-	
Ē	Pa men tant:		* 4 □ Donation 5 □ Other (Spec		Hu		ematory			2004	Wa.	ldorf,	MD
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		21. Signature of Funeral Service Lic	ensee		22	2. Name and Ad	Idress of Facilit	Robe	rt E.	Evan	s Funer	al Home
ш	20 E # 9		1711				L6000 A1	nnapoli					
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that	t caused the dea	th. Do not en	er the mode of	dying, such as	cardiac or r	espiratory arr	rest,	- 1	Approximate Interval Between
	Pnysician		Immediate Cause (Final	/	Eman DA	Also	Hear	+ Ini	line	0/18.	+ h	liest	Onset and Death
	/Medical		disease or condition resulting in death)	a. Due t	o (or as á conse	nuence of):	HUN	LILL	inu		,		274.3
31	Examiner		1	Duga	it de	at and any							٧
		er	Sequentially list conditions, if any, leading to immediate	b	o (or as a conse	quence of):							
	ed sit	ine	cause. Enter Underlying Cause (Disease or injury	1	22 1	the .							
	and tran	Examin	that initiated events resulting in death) Last	c. Dual	o (or as a conse	CALL A							
Ď.	e be executed /sician and e burial-transit			Due	0 (01 25 & 00156	querice or).							
8760	cate be executed physician and the burial-transil	dicai		J									····
9	tifica ng ph as ti	led											
Box	leath certific attending p	2	IF FEMALE: 23b. Was decedent pregnant		outcome of pregn birth 2 Pet		Ectopic pregna	ancv			23	3d. Date of deli	
ň	leath atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pre	gnant at time of		Other (specify					Month	Day Year
o	the cy the check	ys	9 Unknown	9□ Uni	known								
<u>a</u> .	The law requires that the death certifi ste has been signed by the attending I page 2 should be detached for use as	ģ	Part II. Other significant conditions	contributing to	death but not re	sulting in the u	nderlying cause	given in Part I.		23e. Did to	bacco us	e contribute to	the cause of death?
Š	sign sign d be	by								1 □ Y	es 2	No 3□Pro	obably 4 Unknown
Records,	w require been si should t	Completed	-							-			=
Ö	has b	pie								24a. Was a autop	sy	24b. Were au prior to d	topsy findings available completion of cause of
	The Ite h	PO								perfor 1 ☐ Yes	med? 2. ¥No	death? 1 ☐ Yes	2 □ No
Vital		0	25. Was case referred to medical	1				26. Place	of Death (Check only o	ne)		
	ysician: The is certificate hadinector, page	O B	examiner? 1 ☐ Yes 2.X No	Hospital:	Inpatient 2	ER/Outpatie	nt 3□ DOA	Other	•	-		☐Other (Spec	cify)
o	2 = <u>8</u>	—	27. Manner of Death	28a. Da	te of Injury	28b. Time o	-	Injury at Work?		d. Describe h			,7
5	Jing Afte fune	io	1 Natural 5 ☐ Pending		onth, Day Year)	Injury		Work? 1 ⊟ Yes 2 🗔	No				
S	tend death tor: the	cal	3 ☐ Suicide 6 ☐ Could not	be as Dia	ce of Injury - At I	nome form et				f Location (S	Street and	Number or Ru	ral Route Number,
Division of	or Al	Certification:	4 Homicide determine	ed 200. Fia	ilding, etc. (Spec	ify)	eet, ractory, on	100	201	City or Tow		THURSDON OF THE	ar riodio riambor,
	ital Irs a ral E			1					**				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical Ex	aminer: On the	the best of my kn basis of examin								
	the Fin 24	ed	one)	and m	anner stated.								
	To t To t	Σ	29b. Signature and title of certifier	0.0	MAN		29c. Lic	ense number.	28	1	29d. Date /	signed (Montl	n, Dey, Year)
			Hrus	ER.	IVI		D	448	00		1-	7-04	
			30 Name and address of person w	completed ca	suse of death (Ite	m 23a) (Type	Print)	0	.1	N	0	4.4	0 5 144.4
		-	SUSAN KRIFF	ER. 1	us.	2191	De	tence.	HWU	U	01/10	n MI	21114
	Sta	ate.	31. Date filed (Month, Day, Year)	32	. Agistrar's Sign	ature			/			1	
	Regist		IAN 12	2004	Alexan .	Mr.	Lack a		/				

			For State Registrar	State of	Maryland /		artment rtificate			and M		giene	2004	National Assessment	593
	Physici	6	1. Decedent's Name (First, Middle, L	ast)							2. Date of Dea Month	ath Day	Yeer	3. Time of	Death
	/Medic			Mulrean							January	7 11,	2004	8:00	A M
	Examin	er	4a. Facility Name (If not institution, g						Location o	f Death			ounty of Deeth		
	Funeral		Anne Arundel Med 5. Social Security Number 6.		. Age (In yrs. last t	oirthday)	If Under	1 Year	olis If Under:		8. Date of Birth	h	nne Aru	INGEL plece (State ontry)	r Foreign
	Director		061-09-8936	1□M 2XF	94	Yrs.	Months	Days	Hours	Min.	(Month, Day Dec. 27			ntry) W York	
	D ≥ 00		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wo or Lo	ocation				Wile-			10d, Inside Ci	
	Aaryla Fed a	5	Maryland Anne A	rundel	Too. Oily, To		lgewat	er						1 Tyes	•
	the N	Funeral Director	10e. Street and Number				10f. Zip					10g. Citize	n of What Cou	ntry?	
	h with	i D	439 Poplar Leaf	Drive				210	37			[]5	SA		
	deat	ner	11. Marital Status		dent Ever in U.S.	13.	Was Deced			gin? (Spe	cify Yes or No- Rican, etc.)		Race - Ameri Black, White		
36	or It	y Fu	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 If Yes, Give	2 ∑ No	ĺ	1 ☐ Yes 2		Specify:	, , , ,	110411, 010.7		necity:		
Ö	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show lited Examilian must be routiled at	ed by	3 🕅 Widowed 4 ☐ Divorced	Year or Dat	,	a Dece	dent's Usua	I Occupa	tion				of Business/Ir	hite	
15	n ne	plet	(Specify only highest g	rade completed)		(Give	kind of wor DO NOT us	k done d se retired,	uring most	of working	ng	TOD. KING	Of Businessyll	luustiy	
212	d within grane.	Completed	12th	College (1-	401 5+)	НС	memak	er				I	Home		
pu	be filed tal Hygid d other	Be	17. Father's Name (First, Middle, Las						18. Mothe		(First, Middle,		ımame)		
yla	should be nd Mental marked o	္	Patrick								en McNe			***	
Maryland 21215-0036	nd 2 sho lith and 27 Is m		19a. Informant's Name/Relationship								Route Numbe			o Code)	
d)	Te Hea		Stephen Mulrean 20a. Method of Disposition	SOII	20b. Place	of Dispo	heele	ne of			Nyack,		tion - City or To	own, State	
ē	Pages ent of nt: # i		1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Special Control of Cont		tate	-	matory or of Cemet		"	1–13	-04	Oueer	ns, New	York	
Baltimore,	permit. Pages : Department of H Important: If ite any injury or ot once.	1	21. Signature of Funeral Service Lic						s of Facility		rge P.				e
Φ_	permi Depa Impo any ii	11	* Word Ville	ll-							d Rd. E				
8760,	Physician /Medical Examiner up prize	ical Examiner	shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (o	as a consequence	e of):	un	di	a/	efi	olog	y		Interval Beth Onset and I	ween Death CCF
P.O. Box 687	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 ☐ Live bir	ome of pregnancy th 2 ∐ Fetal dea nt at time of death wn		Ectopic pre					23d	I. Date of delive		'ear
	luires that n signed t	by	Part II. Other significant conditions O Newwo	onia					n in Part I.		T .	bacco use es 2XN	contribute to the	he cause of do	
Division of Vital Records,	The ate ha	Completed	Chimic (obstru	etine	pu	lmor	ray	dis	orda	24a. Was a autops perfore		24b. Were auto prior to co death? 1 ☐ Yes	ppsy findings ampletion of ca	available ause of
Vita	Physicien: r this certificanal director.	Be	25. Was case referred to medical examiner?	Hospital:				. Othe	0.00		(Check only or				
of	Physic this stal di	To To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of		. Time of	nt 3 DO:	Bc. Injury Work	4 🗀 Nui		ne 5 Reside 8d. Describe he			y)	
lon	ading ith. : Afte e fune	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigate		, Day Year)	Injury	М		? 'es 2 □ N			, ,			
Divis	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not 4 Homicide determine	4 286. Place C	of Injury - At home, g, etc. (Specify)	farm, str	eet, factory,	, office		2	8f. Location (Si City or Town	treet and N n, State)	lumber or Rura	al Route Num	ber,
	To the Hospital of within 24 hours af To the Funerel Completely filled in	Medical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	thysician: To the base aminer: On the base and manne	est of my knowled sis of examination a or stated.	ge, deati	h occurred a vestigation,	at the time in my op	e, date and inion, deat	d place, a h occurre	nd due to the c d at the time, d	ause(s) an late a <i>n</i> d pla	d manner as s ace, and due to	tated. the cause(s))
	To the To the Comp	ž	29b. Signature and title of certifier	0.	530			License		. ,	2	9d. Date s	igned (Month,	Day, Year)	
,			Stonia -	Klom	7			D	481	01		Jai	ruca,	11,2	004
				mbesin) (Type,	Print)	al Pa	ukw	an S	inte 39	50 A	nnapol	1240DS	1401
	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 2	2004 32. Re	elstrar's Signature		Aco. H			U					

DHMH 17 Rev 1/2001

ORIGINAL

			. For State	of Maryland / Dep	artment of H	lealth and M	•	•	e.				
			1 - State Registrar	Ce	rtificate of	Death	Reg	g. No.	U4 U159L				
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Y	3. Time of Death				
	/Medi		Mary Frances Mason				January	4, 2004	4:25 P M				
	Examir	ier	4a. Fecility Name (If not institution, give street and Ginger Cove Health (r Location of Death		4c. County of					
			5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Annapo	If Under 24 Hrs.	9. Date of Birth	Anne A					
	Funeral Director		163–16–3162		Months Days	Hours Min.	8. Date of Birth (Month, Day,) March 5,	/ear) 1 0 2 Ω τ	Birthplace (State or Foreign Country) Pennsylvania				
			Usual Residence of Decedent	03		<u> </u>	accii J,	1920 1	emisyrvania				
	nylan how		10a. State 10b. County	10c. City, Town or Lo	111	-			10d. Inside City Limits				
	Be-f e	cto	Maryland Anne Arundel	Anna	apolis				1 □ Yes 2/CXNo				
	or 2	Director	10e. Street and Number		10f. Zip Code		100	g. Citizen of Wha	at Country?				
	ath v		4000 River Crescent D			21401		USA					
	er de Item	Funerai	Armed	ecedent Ever in U.S. 13. Forces?	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No- lican, etc.)		American Indian, White, etc.				
39	urs aff	by F	1 Never Married 2 Married 1 XYe If Yes, Year o	s 2 No Give Dates: W.W. II	1 ☐ Yes 2 X No	Specify:		Specify: V	hite				
21215-0036	within 72 hours after death with the Maryland ane. than "natural; or Iteme 23a or 28e-f ehow he Modeal Examinar must be notified at		15. Decedent's Education	16a. Dece	dent's Usual Occup	ation	16	6b. Kind of Busin					
218	thin 7	ple	(Specify only highest grade complete Elementary/Secondary (0-12) College	d) (Give life.	kind of work done of DO NOT use retired	during most of working d)	g		,				
7	filed wi Hygien other th	Completed	4 ye	· · · · · · · · · · · · · · · · · · ·	se		1	Medical					
nd	m = 0 5	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		-					
yla	2 should be and Mental Is marked of aumatic ever	မ	Francis McGert				nes Rudde						
Mar	12 sh h and 7 Is m rraum		19a. Informant's Name/Relationship (Type, Print)			and Number or Rural							
e,	1 and Healt em 2 ther		Bert A. Mason/ Son 20a. Method of Disposition	20b. Place of Dispo		r Rd., Sev			21146 y or Town, State				
nor	ages nt of t: If it	ll i	1 X Burial 2 ☐ Cremation 3 ☐ Removal fro	m State cemetery, crei	matory or other plac	(e)							
Baltimore, Maryland	artme orten injur		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligensee			ery 1-7-0		Cresapto	own, MD neral Home				
B	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked any injury or other traumatic evonce.		Vant Villale	- 2	973 Solom	ons Island	d Road,	Edgewate	er,Md.21037				
34			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause o	t caused the death. Do not ent					Approximate				
16	Physician		Immediate Cause (Final disease or condition	Deimen	Ti.a				Interval Between Onset and Death				
	/Medical		resulting in death)	o (or as a consequence of):	110				Years				
	Examiner		Sequentially list conditions, b.										
	sit s	Examiner	if any, leading to immediate Due cause. Enter Underlying Cause (Disease or injury	o (or as a consequence of):									
	and and III-tran	хап	that initiated events c.	o (or as a consequence of):									
760,	tte be executed sysicien and ne burial-transit	calE		- (
89	ficate g phys	edic	d										
Вох	Attending Physician: The law requires that the death certificat refeath. refeath. setter, ether this certificate has been signed by the attending phy effor the refeath of the funeral director, page 2 should be detached for use as the	by Physician/Medi		outcome of pregnancy				23d. Date of	delivery				
œ.	death e atte	icia	in the past 12 months?	gnant at time of death 5	JEctopic pregnancy Other (specify)			Month	Day Year				
P.O.	at the by th	hys	9 Unknown 9 Un										
'n	es the		Part II. Other significant conditions contributing to	death but not resulting in the us	nderlying cause give	en in Part I.	23e. Did tobac	co use contribut	e to the cause of death?				
ord	w require been sig should b	ted	Diabeles Me	411/03			1 🗆 Yes	2 10 No 3	Probably 4 Unknown				
Division of Vital Records,	a law has b	Completed			<u></u>		24a. Was an autopsy	prior	autopsy findings available to completion of cause of				
<u>e</u>	rcate						performed 1 ☐ Yes 2 €		h? Yes 2□ No				
<u> </u>	ician certifi rector	Be	25. Was case referred to medical examiner? Hospital:		Othe	26. Place of Death							
of	Physician: The law rr this certificate has b ral director, page 2 s	7:	1 1es 2 M/140 . 1[Inpatient 2 ER/Outpatien e of Injury 28b. Time of	3L DUA	441 Nursing Hom	e 5 Residence d. Describe how		Specify)				
on	th: Afte	tlor	1 ☑ Matural 5 ☐ Pending (Ma 2 ☐ Accident investigation	onth, Day Year) Injury	Work	(? Yes 2 □No		injury occurred					
NIS.	or Attending I after death. Director: After in by the funer	ifica	3 Suicide 6 Could not be determined 28e. Pla	ce of Injury - At home, farm, stre	eet, factory, office	28	f. Location (Stree	t and Number o	r Rural Route Number,				
٥	tal or A rs after at Direct ed in by	Certification;	4 Tromode	ding, etc. (Specify)			City or Town, S	itate)					
	To the Hospital or within 24 hours after To the Funerat Dir. completely filled in [edicai	29a. Certifier 1 Certifying Physician: To t 2 Medical Examiner: On the	basis of examination and/or inv	occurred at the time	e, date and place, an	d due to the caus	e(s) and manne	r as stated.				
	thin 2 thin 2 the 1	Med	And me	inner stated.									
	F 3 F 8		I Joseph MEN	en	017	965	290.	15/0	July, rear)				
		}	30. Name and address of person who completed on	use of death (Item 23a) (Type I	Print)	-	.,	/ /	/				
	very dependent and the second		Joseph Friend	0	1 12 .	. Anna	ne lii u	rd. 214	101				
			4.46.5.2				y						
Di i			JAN U 6 2004	There & A	books								
UHN	лн 17 Rev 1/20	30. Name and address of derson who completed gause of death (Item 23a) (Type, Print)											

ORIGINAL

			1 - For State Registrar	State of N	Marylar		artment tificate			and Mo	ental Hy	/gien Reg. N	2011	. 0	595
ľ	Physic		Decedent's Name (First, Middle, Declare: TE								2. Date of D Month	Da	ay Yea	ar l	e of Death
	/Medic Examir		Ruby E. 4a. Fecility Name (If not institution, Joseph Ritchey H	give street and numbe	ryman		Bal	timo	Location o		Januar		2004 c. County of D		
- 1.	Funeral Director		5. Social Security Number 246-22-2971 Usual Residence of Decedent	6. Sex 7. A 1 □ M 2 √ F	Nge (In yrs. 85	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min.	B. Date of Bi (Month, D March	ay, Year	7)	Birthplace (Sta Country) orth Ca	nte or Foreign arolina
	e Maryland 8a-f show	ctor	10a. State 10b. County Maryland			ty, Town or Lo									e City Limits ∕es 2 ☐ No
	uh with th 23e or 26 val be no	Funeral Director	10e. Street and Number 713 Maiden Choi	ce Lane Ap	t. 14	11	10f. Zip	Code 1228				10g. C U.S.	itizen of What .A.	Country?	
9036	in 72 hours after death with the Maryland i "natural", or flema 23e or 28a-f show ledical Examinet must be notified at	d by Fune	11. Marital Status 1 Never Married 2 Marrie 3XXWidowed 4 Divorced	12. Was Deceder Armed Forces at 1 Tyes 2 If Yes, Give A Year or Dates	s? X ^{No}	1	Vas Deced f Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto F	cify Yes or N lican, etc.)	0-	14. Race - A Black, W Specify: W		1,
Maryland 21215-0036	s within plene. r than	Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		r 5+)	16a. Deced (Give life. 1	kind of wor OO NOT us	k done di e retired)	tion u <i>ring</i> most ecial		g		Kind of Busine Printi		
yland ;	be file ital Hyg od othe event,	To Be C	17. Father's Name (First, Middle, L Charles Cols	ston Mc	Nei1				Ros	ie	(First, Middle Vio	1a	Trip		
	and 2 saith ar n 27 is er trau		19a. Informant's Name/Relationshi Rev. Ray Blanset			306 M	eares	Cou		Annaj	polis,	Mar	or Town, State yland	21401_	
Baltimore,	permil. Pages 1 Department of He Important: If iten any injury or oth		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	ecify)	Lor	Place of Dispo cemetery, crem raine & Maus	park (her place Ceme i	tery	1/9	/2004	Ba1	ocation - City Ltimore	, Mary	land
Bai	Depar Impor any in		21. Signature of Funeral Service Li	2		1	. Name and	Annaj	polis	Road	d, Bow	ie,	ns Fun Maryla	nd 207	15
	Physician /Medical Examiner		23a. Part1. Enter the disease of c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or a	on (Cance									Between nd Death
8760,	sate be executed only sician and the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a											
O. Box 6	the death certific y the attending p iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	ildeath 3□	Ectopic pre Other (spe						23d. Date of o	lelivery Day	Year
ords, P.	law requires that as been signed b 2 should be deta	by	Part II. Other significant condition	s contributing to death	but not res	ulting in the ur	derlying ca	use giver	n in Part I.				use contribute		of death?
al Reco	The ate h page	Completed								_	24a. Was auto perfo 1 \(\text{Yes} \)		prior t death		gs available of cause of
Division of Vital Records,	Attending Physician: 1 r death. ector: Atter this certifical by the funeral director, p.	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investiga	28a. Date of In (Month, D	ury	ER/Outpatien 28b. Time of Injury		Other c. Injury a Work?	: 4 ☐ Nur	sing Home	(Check only only only on the second of the second on the	dence	6 XOther (Sp	pecity) 1-10	spice
Divis	D it to	Certification:	3 Suicide 6 Could no 4 Homicide determin	and 288. Place of I	njury - At ho etc. <i>(Specif</i>	ome, farm, stre	et, factory,	office		28	If. Location (City or To		nd Number or . e)	Rural Route N	um <i>ber</i> ,
	To the Hospital within 24 hours a To the Funeral completely filled	edicai	29a. Certifier 1 Certifying (Check only one)	Physician: To the bes xaminer: On the basis and manners	of examina	owledge, death tion and/or inv	occurred a estigation,	t the time in my opii	, date and nion, deatl	l place, an	d due to the at the time,	cause(s date and) and manner d place, and d	as stated. ue to the cause	θ(s)
)	To t To t	Σ	29b. Signature and title of certifier	£	l'e	.)		License		3			te signed (Mo		•
			30. Name and address of person w	tand fo	, r-d	MO	Print)	828 05ef	N. E	utaw Rick	St. Ba	ltii fos	06/09 more, N	Marylan	d
8	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 8	2004 32. egis	trar's Signa	ature A	now.	i							

4019/1

Puly E. Heryman

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 8:13 P M Mary G. Marshall January 8, 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2900 Shipmaster Way, #304 Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 17, 1927 Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 X F 220-16-9098 76 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County r than "natural", or Items 23s or 28s-f ahow the Medical Example remark be notified at 1 ☐ Yes 2XXIIIo Director Annapolis Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2900 Shipmaster Way, 304 21401 **USA** death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XON0 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten eny injury or other traumatic event, the Medical Example 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: White δ 3XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Goddard, Sr. Marie Brandt ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie M. Krause/ Daughter 427 Edgemere Drive, Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Our Lady of Sorrows 1-12-04 West River, MD 21. Signature of Funeral Service Leenses 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SVV /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physician and ned for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown been sig 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has 2/2 No certificate 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident I Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29d. Daje signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number low who completed cause of death (Item 23a) (Type, Print) 30 Name and address of person lonich, wo UOV 31. Date filed (MoJA Registrar's Signature State 2004 Registrar

Amend Item #19a peState of Manyland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death January I, 2004 **Physician** Melva Pearl McKenzie 5:00 a.m. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Goodwill Mennonite Home Grantsville Garrett 8. Date of Birth (Month, Day, Yea Dec 30, 1 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours 1 □ M 2 🖬 F Director 220-40-1125 1936 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other then "natural", or items 23e or 28a-f show treumatic event, the Medical Examiner must be notified at MD Garrett Grantsville 1 ☐ Yes 2 X No Director 10f. Zip Code 10e Street and Number 10g, Citizen of What Country? 1025 Springs Road 21536 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours efter 1 ☐ Never Married 2 Married 1 ☐ Yes 21 No If Yes, Give white Baltimore, Maryland 21215-0020 1 ☐ Yes 2 A No Specify: Specify: lf Yes, Give Year or Dates: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then "eny injury or other treumatic event, the Meseny injury or other treumatic event, the Meseny Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 8 th Own Home 17. Father's Name (First, Middle, Last)
James Bittinger 18. Mother's Name (First, Middle, Maiden Sumame) Be Della Hoover 19a frigmant's Name/Relationship (Type Print)
Fdward J. Bittinger/husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1025 Springs Rd., Grantsville, MD 21536 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Grantsville Cemetery Jan 4, 2004 Grantsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A., PO Box 275 21. Signature of Funeral Service Licensee uman 179 Miller St., Grantsville, MD Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CARDIAC ARREST Examiner Examiner attending physician and I for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury unal initiated events certificate be exec OROWARY ARTERY

Due to (or as a consequence of): Box 68760. Physician/Medical resulting in death) Last DEPENDENT DIABETES MELLITUS Division of Vital Records, P.O. cate has been signed by the a page 2 should be detached to Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown CONGESTIVE HEART FAILURE ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed performed? 1 Yes 2 No 1 Yes 2XNo or Attending Physicien: efter death. Director: After this certifica the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 □ Residence 6 □ Other (Specify) 1 Yes 2 No ၉ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 2 ☐ Accident To the Hospital or Atte within 24 hours efter de To the Funeral Directo completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0034231 Jan 2, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bissell, M.D., 124 Miller St., Grantsville, MD 32. Regist r s Signature 31. Date filed (Month, Day State

Registrar

Amended #20c, nls, 01/06/04, Allegany Co.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydienes O. O.

			For Stata Registrar	State of Mar		artment of Hea <i>rtificate of De</i>		tal Hygie Reg.	2004	01598
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	/Medic	al	RUTH LEE MI 4a. Facility Name (If not institution, give	LLER		4b. City, Town, or Loc		NUARY	4, 2004 4c. County of Death	10:02 A M
н	Examin	er	813 MT. ROYAL			CUMBERI			ALLEGAN	JV
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs. last birthday)	If Under 1 Year If		ate of Birth Month, Day, Ye		place (State or Foreign
	Director		217-28-7642 Usual Residence of Decedent	□M 2 X F 7	1Yrs.			R. 9,19		' VIRGINIA
	yland		10a. State 10b. County	1	Oc. City, Town or Lo	cation				10d. Inside City Limits
	e Mar	ctor	MD ALLEG	ANY	CUMBER	LAND				1XYes 2□No
	with th	Dire	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cour	ntry?
	death with the Maryland ms 23a or 28a-f show f must be notified at	Funeral Director	813 MT. ROYAL	AVENUE 12. Was Decedent Eve	arin IIS 13 V	21502	nic Origin? (Specify	Yes or No-	U.S.A.	can Indian
936	be filed within 72 hours after death with the Marylan trai Hygiene. Id other than "natural", or liems 23a or 28a-f show ovent, Ira Madical Exertirer must be natified at	ρ	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hispan f Yes, specify Cuban, M 1 ☐ Yes 2√2 No Si	lexican, Puerto Ricar pecify:	n, etc.)	Black, White, Specify: WHI	etc.
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Maryland	2 shou and N is ma		19a. Informant's Name/Relationship (Туре, Print)	19b. Mailin	g Address (Street and	Number or Rural Rou	ite Number, Ci	ty or Town, State, Zip	Code)
	s 1 and 2 should if Health and Men Item 27 is marke other treumatic		MARK MILLER	/ SON	803 20b. Place of Dispo	FLETCHER	DRIVE, C	UMBER	LAND, MD	21502
Baltimore,	00		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special	Removal from State by)	CUMBERIAN	natory or other place) ID CREMATOR	Y 01/05/2	C	Location · City or To umberland CUMBERLAN	
Ball	permit. Pag Department Importent: I any injury o	() ()	21. Signature of Funeral Service Lice	whend	U	Name and Address of PCHURCH FU	NERAL HOME		MD MD 24	1502
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Вох		an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		Ectopic pregnancy		<i>\)</i>	23d. Date of delive	,
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Division of	el or Att	Certification;	3 Suicide 6 Could not b 4 Homicide determined		- At home, farm, stre Specify)	eet, factory, office	28f. L	ocation (Street lity or Town, St	and Number or Rura ate)	l Route Number,
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	To the To the Comple	Me	29b. Signature and title of certifier	11	c M	29c. License nur	mber	29d. I	Date signed (Month,	Day, Year)
	6		30. Name and address of person who	completed cause of deat	b.(Item 23a) (Type	Printy >	0 5 73	1	15/0	4
4	nds		R. ESP	32 Registrar's	102 Se	ton 1)	rive,	Ca	mber/	MA
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	Funeral		5. Social Security Number 6. S	DM ODE	(In yrs. last birt 65	Months		Hours	Min.	Date of Birth (Month, Day, -28-19	Year)	9. Birti Co Ra 1 +	hplace (State o	r ⊢oreign MD
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	yland		10a. State 10b. County	1	IOc. City, Town	or Location							10d. Inside Ci	
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M	nd 2 :		Patricia A. Mroz	- wife	5	322 Dori	s Dr	ive,	Waldo	rf, MD	20	601		
กั	is 1 and 1 a		20a. Method of Disposition		20b. Place of	Disposition (Nat	me of other place	9)	Date		20c. Loc	ation - City or	Town, State	
Ē	Page nent c nnt: If ury or		1 ☐ Burial 2 XX Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify		1	Cremato		1	-8-200)4	Wald	orf, ME)	
pairimo	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tree	by	21. Signature of Funeral Service Licer	haun Moi	0053	22. Name a Hunt	d Address	s of Facility neral	Home Wald	orf, M	D 2	0604		
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	To the h within 2 To the f complete	Med	one) 29b. Signature and title of certifier	and manner state	ed. 	29	c. License	number		2	9d. Date	signed (Monti	h, Dav, Year)	
}	7 × 10 0	-	25D. Signature and the of cartines			20	חשב	16001	í		/-	07-2	004	
			30. Name and address of person who	completed cause of dea	ath (Item 23a)	(Type, Print)	10 1	00/			111	-/ 0		
1	31b		Robert Peter	son MD	1	Amo	- /	Anna	elos	Mdo	1140	/		
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 9	completed cause of deal source of the bast of and manner state of the bast of	's Signature	Sperk	2							

		For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artment of Hertificate of L	ealth and N Death		giene 2 (004	01600
A Property and		1. Decedent's Name (First, Middle, La	st)				2. Date of Dea Month	ith Day	Year	3. Time of Death
Physi /Med		Alma	Ruth	Mah	oney		Januai		004	6:29P M
Exam		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Death		4c. Count	y of Death	
		Bowie Health Ca			Bowie	If I had a O.4 Han	100	Princ	e Geor	
Funera		5. Social Security Number 6. S 049-05-2736	Sex 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	Month, Day	, 9,1918	9. Birthpli Count CT	ace (Stete or Foreign ry)
Directo	or	Usual Residence of Decedent	- AA 03				bept.	J, 1J10		
land ow		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10	d. Inside City Limits
Mary Find	to	Maryland Prince G	eorge's Un	oper Ma	rlboro					1 ☐ Yes 2 No
ith the Marylan or 28a-f show	lrec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	ry?
th will	Funeral Director	17128 Fairway V	iew Lane		207	72		U.S.	A	
r dea	laer	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Ra Bla	ce - America ck, White, e	
or II	bv Fi		1 Yes 2 No If Yes, Give XX Year or Dates:		1 □ Yes ② No	Specify:		Speci	^{∱y:} Whit	-0
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and		Sheila Hutson (D			28 Fairwa	y Fiew L				
Pages 1 nent of Hi int: If Iter	1	20a. Method of Disposition 1 Burial 2 Cremation 3 [cemetery, crer	sition (Name of matory or other place	e) I.Tan	7 - 2004	20c. Location		
Pag iment tant:		` 4 ☐ Donation 5 ☐ Other (Speci	(y) _L	e Crem	atory Name and Addres	Doi:	7,2004	Clinto	n, Mar	ryland
permit. Pages Depertment of Important: If it sny injury or o	once	21. Signature of Funyral Survivy Lice								n, MD20735
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		shock, or heart failure. List only	one cause on each line.	III. DO NOL BIN	er the mode of dying	g, soon as cardiae	or respiratory ar	1031,		Interval Between Onset and Death
Physicia /Medica		Immediate Cause (Final disease or condition resulting in death)	a <u>Cardia</u>		thmia					
Examine		1	Due to (or as a conse	quence or):						
, \$\display \$\display \text{\$\display \t	9	Sequentially list conditions, I any, leading to innerdiate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consu	quence of						
suted ad ransit	Examiner	Cause (Disease or injury that initiated events	С.							
certificate be executed dring physicien and ise as the burial-transit			Due to (or as a conse	quence of):					- 4	
ate by hysic the by	E2		d							
as a s	Physician/Med	IF FEMALE:	23c. It yes, outcome of pregr	20001						
attendir for use	ue s	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fel	al death 3	Ectopic pregnancy Other (specify)				ate of deliver lonth	Day Year
be de ched	Vslo	1 ☐ Yes 2 ☐XNo 9 ☐ Unknown	9☐ Unknown	death 3L		,				
The Cords, F.O. DC. The law requires that the death ate has been signed by the atter bage 2 should be detached for u	4	Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use cor	ntribute to the	e cause of death?
v requires to been signed should be	od by						1 🗆 ነ	∕es 2□No	3 🔲 Proba	ably 420nknown
w req	Completed						24a. Was			sy findings available
VIIAI NEC sicien: The law certificate has t irector, page 2 s	a de							rmed?	prior to condeath?	apletion of cause of
	a	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes	2 No	163	20110
	0	1 Yes ŽQNo	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA Othe	0.00	ome 5 Resid		her (Specify)
ding Phys h. After this funeral di	- i		28a. Date of Injury (Month, Day Year)	28b. Time o	t 28c. Injury Work	/ at	28d. Describe h	now injury occu	rred	
Attending r death. ector: After by the fune	1	1 Natural 5 Pending 2 Accident investigation	on	.,,		Yes 2 □ No				
DIVISION Attender after death I Director:	ertification.	3 Suicide 6 Could not determined			reet, tactory, office		28t. Location (S City or Tox		ber or Rural	Route Number,
the Hospital or his 24 hours after the Funeral Dirumpletely filled in In										
Hosp 14 hou Fune Telly fill	la cipa	29a. Certifier 1 Certifying P	hysicien: To the best of my kr miner: On the basis of examin							
To the Hospital or At within 24 hours after or To the Funeral Direct completely fitted in by	M	one) 29b. Signature and title of certifier	and manner stated.		29c. License	e number		29d. Date sign	ed (Mpnth, (Dey, Year)
₹ <u>₹</u> %		1	7 6/2	04.5	0 00	0074	00	, 14	Inc	/
'		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type.	Print)	03/		1/0	1 - 1	
133			THOMAS, MI	7 1:	221 ME	ERCAN:	TILE	LANE	, LA	RGO, MD
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			For State Registrar	State of	Marylar		artmen <i>rtificat</i>				lental H	ygien Reg. No	- 7 111	04	016	
۲	3		Decedent's Name (First, Middle,	Last)							2. Date of D	eath			3. Time of De	ath
ķ.	Physici /Medic		Peggy	A. Maa	ass	<u>-</u>					Month Janua:	${f ry} 1$,	2004	ear	5:15P	M
	Examin		4a. Facility Name (If not institution,	give street and num	iber)		4b. City,	Town, or	Location	of Death		40	. County of I	Death		
		_ 0	5106 Brookview D 5. Social Security Number 6		7. Age (In yrs.	last hinth days		theso	la If Under	24 Hrs	0.0-1		lontgo			
neigh.	Funeral Director		474-54-4596	1 M 2 X F	4.5 Age (iii yis.	V	Months		Hours	Min.	8. Date of B (Month, D Sept	ay, Year,			ece (State or P ry) esota	oreign
			Usuel Residence of Decedent							I.	верс.	19.)			
	show).	10a. State 10b. County		10c. Cr	ty, Town or Lo	ocation							10	d. Inside City I	
	the M	Directo	Maryland Montgo	mery		Beth	lesda 10f. Zip	Codo				10- 0	tizen of Wha	A C = 1 = 1		
	an or	DI	5106 Brookview D	nivo.				20816							•	
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õ	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "neturel", or Itams 23e or 28e-f show event, the Medical Exertirer must be notified at		1 ☐ Never Married 2 Married	If Voc Chie	2 No		ir Yes, spec 1 □ Yes		Specify:		Rican, etc.)		Black, \			
ğ	ural",	d by	3 Widowed 4 Divorced	Year or Da	tes:Vietr	nam							Specify: W			
Maryland 21215-0036	in 72	Completed	15. Decedent's (Specify only highest	grade completed)		16a. Dece (Give life.	dent's Usua kind of wo DO NOT us	rk done d	urina mos	t of worki	ing	16b. K	and of Busin	ess/Indu	ustry	
7 7	d with giene. r than	шо	Elementary/Secondary (0-12)	College (1- 4	4or 5+)		tems					Fed	leral	Gove	rnment	
9	e filed al Hygi I other vent, I	BeC	17. Father's Name (First, Middle, La	st)		·				er's Name	(First, Middle					
Z		To	Phillip Maass						Loi	s Jea	an Amur	ndsor	1			
<u>aa</u>	2 se ar		19a. Informant's Name/Relationship			1					al Route Numi				Code)	
o,	1 and Health em 27 other tr		David W. Baker/S	pouse	20b. F	5106 Place of Disponentery, crer					Betheso Bate	7	D 208 ocation - City		m State	-
פֿר	ages ant of it: If it		1 ☐ Burial 2 🖾 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		late				1							
saitimore,	permit. Pages 1 and Department of Health Important: If Item 27 ony injurker other tr		21. Signature of Funeral Service Lice		Che	esapeak	ce Cre 2. Name an	emato nd_Addres	ory s of Facilit	X OT\O	6/2004 cal and	Be.	ltsvil	le,	MD	
ď	Ded Times		1 Willing &	. Dom							cal and					
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that cally one cause on ea	used the deat ch line.								***********	1	Approximate nterval Betwee	
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	/Medical Examiner		resulting in death)	Due to (c	r as a conseq	juence of):										
ő		e.	Sequentially list conditions, if any, leading to immediate	b. — Due to (c	or as a conseq	uence of):					<u>.</u>					
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Ď,	e exec ian an ırial-tr		resulting in death) Last	Due to (c	r as a conseq	uence of):										
8/60	certificate be executed ding physician and use as the burial-transit	dicai		d										_		
×	a ge	/Med	IF FEMALE:	23c. If yes, outcome	ome of pream	ancy.						- 1		200		
200	death of attention ad for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live bir	th 2 Fete	I death 3	Ectopic pro						23d. Date of Month		∕ ∕ay Yea⊓	r
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000	w require been si should b										1 🗆	Yes 2	ŽNo 3□] Probab	oly 4 □Unkr	nwor
d)	> 0.0	ompieted									24a. Was	psy	prior	to comp	y findings ava-	lable e of
	T ate	Co									perfe 1 ☐ Yes	ormed? 2 2 No	deati	77	□ No	
VII	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only					
	y Phys ar this eral dir	\vdash	1 ☐ Yes 2 ₹ No 27. Manner of Death	28a. Date of	patient 2	28b. Time of		8c. Injury	at INUI		ne 5 🔀 Res 8d. Describe			Specify)		_
<u> </u>	Attanding F r death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigat		, Day Year)	Injury	м	Work¹ 1 □ Y	? es 2.⊟1							
DIVISION	or Atterderies de irecto	ertification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	286. Place C	of Injury - At ho g, etc. (Specif	ome, farm, str	eet, factory	, office		2	28f. Location (City or To			Rural F	Route Number,	
2	oital ours af	O	×6										,			
	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the funeral process.	edical	29a. Certifier 1 Certifying 1 (Check only one) 2 Medical Ex	Physicien: To the base aminer: On the base and manne	sis of examina	wledge, death tion and/or inv	n occurred a restigation,	at the time in my opi	e, date and inion, deat	d place, a th occurre	ind due to the ad at the time,	cause(s) date and	and manner place, and	r as state due to th	ed. ne cause(s)	
	vithin o the	Me	29b. Signature and the or countries	11/	5.00.00.		29c	License	number			29d. Dat	e signed (M	onth, Da	ly, Year)	
	4		Dellett	The			_ (300	14	101	8	01	1/05	10	4	
	Y		30. Name and address of person wh	o completed cause	of death (Item	1 23a) (Type,	Print)	7	F_ 1-	+0	- U		101		/	
			Charles Harrison		1 Munc		Mill	Road	; Roc	kvil	le, MD	208	55			
	Sta Registr		31. Date filed (Month, Day, Year)		gistrar's Signa کیمنام	ture	200	acate da	1							

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Marylar	nd / Depa	artment of He	ealth and	Mental Hygi	•	+ 01603
	Physic	ian	Decedent's Name (First, Middle, Last					2. Date of Death Month	Dey Year	3. Time of Death
	/Medi Examii		Mary Martha Mahe: 4a. Facility Name (If not institution, give			4b. City, Town, or L	ocation of Dea	January th	1, 2004 4c. County of Dea	1:30 A'''
	Funeral Director		20600 Dubois Cour 5. Social Security Number 6. Se	7. Age (In yrs.	·Vea	Montgomer If Under 1 Year Months Days	y Villa If Under 24 Hrs Hours Min	8. Date of Birth (Month, Day,		thplace (State or Foreign ountry)
			214-42-0033 Usual Residence of Decedent	* 105)			April 14	,1898 Mar	,
	e Maryla 3a-f ehov	ctor	10a. State 10b. County Maryland Montgome		ty, Town or Lo	cy Village				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with th	ai Director	10e. Street and Number 20600 Dubois Court			10f. Zip Code 2088		100	g. Citizen of What Co USA	ountry?
020	within 72 hours after death with the Maryland ene. then "natural", or Items 23a or 28a-f ehow the Mudical Examinat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cuban,		Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify:	e, etc.
Z 1 3-0030	thin 72 hours e. en "natural', Medical Era	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	16a. Dece (Give life.	dent's Usual Occupati kind of work done du DO NOT use retired)	on ring most of wa	rking	b. Kind of Business	Thite Industry
N	be filed with ital Hygiene. id other ther event, Italia	Com	Elementary/Secondary (0-12)	College (1-4or 5+) 4	Teac	her			Education	
yland	ould be f Mental I arked ot atic ever	To Be	17. Father's Name (First, Middle, Last) Michael Manley					me (First, Middle, Ma	ŕ	
ž, Mar	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 le marked any injury or other traumatic ev 000ce.		19a. Informant's Name/Relationship (Ty Mary Catherine Mon	ite Daughter	7109	ng Address (Street an	d Number or R	ural Route Number, C	City or Town, State, 2	and 20815
ballillore,	ment of H tment of H tant: If ite		1 ☐ Burial 2 ☑Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	Removal from State Me	emetery, crer tropoli	sition (Name of matory or other place) Ltan ematory	İ	Date 20	c. Location - City or	Town, State
מ	Depar Depar Impor any in		21. Signature Funeral Service Licens	afes	Fr 50	Name and Address ancis J. (Universi	of Facility Collins Lty Blvd	Funeral H	ome, Inc.	8
÷	Physician		23a. Part1. Enter the disease, or compleshock, or heart failure. List only or immediate Cause (Final disease or condition	ications that caused the deat ne cause on each line. a. End-Stage Ca	h. Do not ent	er the mode of dying,	such as cardia	or respiratory arrest		Approximate Interval Between Onset and Death
South Action	/Medical Examiner			Due to (or as a conseq	uence of):	Disease				years
	outed ansit	Examiner	Sequentially list conditions, any, leading to innucleate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or se a sone of	uanee of):					
-	icate be executed physician and s the burial-transit	cai	resulting in death) Last	Due to (or as a conseq	uence of):					
2	death certil e attending d for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of di 9 □ Unknown	Ideath 3	Ectopic pregnancy Other (specify)		7.0	23d. Date of deli Month	very Day Year
, 2	quires that n signed b uid be deta	by	Part II. Other significant conditions con	ntributing to death but not resi	ulting in the ur	nderlying cause given	in Part I.		co use contribute to	the cause of death?
1000	ine lav ate has page 2	Completed						24a. Was an autopsy performer	d? prior to death?	topsy findings available ompletion of cause of 2 No
	ysician is certifi director	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	lospital:	ER/Outpatien	Othor		th (Check only one)	e 6 Other (Spec	(A)
5 i	tending rnysician: foath. tor: After this certific the funeral director.	ation: T	27. Manner of Death 1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a: Work?		28d. Describe how		ny)
	To the nospinal or Attending Priysician; within 24 hours after death. To the Eurharal Director: After this certifici completely filled in by the funeral director.	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	eet, factory, office		28f. Location (Stree City or Town, S	it and Number or Ru State)	ral Route Number,
	within 24 hours after of Au To the Funeral Direct completely filled in by	edical	29a. Certifier 1⊠ Certifying Phys (Check only 2 Medical Examir one)	sicien: To the best of my kno- ner: On the basis of examinal and manner stated.	wledge, death tion and/or inv	occurred at the time, restigation, in my opin	date and place ion, death occu	, and due to the caus rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
ì		Me	29b. Signature and title of certifier	10 %		29c. License n			Date signed (Month	
	0		30. Name and address of person who co	impleted cause of death (Item	23a) (Type, F	D 0983	4	Jar	nuary 2, 2	004
	Sta		Barry N. Rosenbaur 31. Date filed (Month, Day, Year)	32. Registrar's Signa	Farra	igut Avenu		ington,MD	20895	
	Registr	ar	JAN 0 6 200	14 Seneva	B	sporks				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Dey **Physician** Mercedes Barry Manders 5, 2004 January 6:45PM /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 2X F Months Director 579-30-5629 30, 1926 Washington, DC Usuel Residence of Decedent Pages 1 end 2 should be filed within 72 hours efter death with the Maryland ment of Health and Mentel Hygiene.

ant: If item 27 is marked other than "naturel", or items 23a or 28a-f show ury or other traumatic event, the Medical Examinar must be notitled at 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director Maryland Montgomery Rockville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5550 Tuckerman Lane 20852 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Š 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David E. Barry Isabel Purcell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) William E. Manders/Son 9141 Brookville Road, Silver Spring, Maryland 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jan. 9, 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Montgomery Department of important: if any injury or 4 ☐ Donetion 5 ☐ Other (Specify) 2004 rium, Inc. | 2004 | Bethesda, Maryland
22. Name and Address of Fecility Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850-2805 Crematorium, Inc. 21. Signature of Funeral Service Licen Rockville, Maryland M00803 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical neumonia Examiner Due to (or as a consequence of) edical Certification: To Be Completed by Physician/Medical Examiner Hospital or Attending Physician: The lew requiras thet tha daath certificete be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yas 2 KNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1⊠Inpatient 2□ ER/Outpatient 3□ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this erai Director: After thi fillad in by the funeral 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigetion 1. Naturel death. 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours after To the Hospital
within 24 hours a
To the Funeral C
completely fillad 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) January 5, 2004 House mo Cristin Calle D0059871

DHMH 16 Rev 6/95

State

Registrar

medical Center Drive Rockville, Maryland 20850

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

Cristin Parker Howe ms

JAN 09 2004

31. Date filed (Month, Day, Year)

9901

32. Registrar's Signature

	ı	1 - State Ragistrar	State of Marylan	-	artment rtificate			d Ment		ene20	04	01605
		1. Decedent's Name (First, Middle, Last)							ate of Death	Day	Year	3. Time of Death
Physicia /Medic		Catherine C. Ma	sters						nuary	1, 200		11:20 PM
Examin		4a. Facility Name (If not institution, give str	reet and number)		4b. City, T	Town, or L	ocation of D	Death	-	4c. County	of Death	
	Ц	Laurel Regional H				aure		11		Princ	ce Ge	eorge's_
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Months	Days	Hours N	Min. 8. Da	ate of Birth fonth, Day,	(ear)		place (State or Foreign ntry)
Director		087-05-5048	84	TIS.				Au	g. 10,	1919	New	York
and w.		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits
Aarytan f show	ō	Maryland Montgomer	, Ç-	ilver :	Sprine							1 ☐ Yes 2 ☑ No
28a-	Directo	10e. Street and Number	у ј.	LIVEL	10f. Zip (10	g. Citizen of W	/hat Cour	ntry?
rs efter death with the Maryla rs of tams 23a or 28a-f shot rants or mark to redified at	٥	3112 Gracefield	D = - 1			2090	2/4			US	٨	
ne 2	Funeral		. Was Decedent Ever in U.	.S. 13.	Was Decede	ent of His	panic Origin	? (Specify Y	es or No-	14. Race	- Americ	en Indian,
or its		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		rres,speci 1 □ Yes 2	_	Mexican, P Specify:	uerto nican	, etc.)		k, White,	
ral'.	by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 165 2	<u>180</u> 140	эрвспу.			Specily.	Whit	.e
72 h	Completed	15. Decedent's Educa (Specify only highest grade of		(Give	dent's Usual kind of work	k done du	ion <i>ring m</i> ost of	f working	10	6b. Kind of Bu	siness/în	dustry
Marithia Maria	du	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use					7 - 1 1		
led w lygier her ti		12 17. Father's Name (First, Middle, Last)		Kecr	eatio		rector			ederal		vernment
be fi	Be										0)	
should be lited within 72 hours efter death with the Maryland and Mental Hygiene. Ind Mental Hygiene. In marked other than "natural", or items 23s or 28s-f show umatic syent, the Medical Exacts and market rediffied.	မ	James Clyne 19a. Informant's Name/Relationship (Type	Print)	19h Mailir	na Address	(Street an			ances	Hoban City or Town,	State Zin	(Code)
d2 s th an trau		William E. Masters/								-		CA 90272
1 and Health Ism 27 other tr		20a. Method of Disposition	20b. P	lace of Dispo	sition (Nem	e of		Date	20	oc. Location -	City or To	wn, State
Pages nat: If its		1 ☐ Bunal 2 ☐ Cremation 3 ☐ Ref 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	emetery, crer roplit			JJa	nuary 2004		۸ ٦	1	77.1 1 1 -
permit. Peges 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'neturenty injury or other traumatic avent, the Medical once.		21. Signature of Funeral Service Licensee			. Name and			2004		Alexan	dria	, Virginia
Ped dim		Brulles 1 Am	ta	F	ranci	s J.	Colli	ns Fu	neral	Home I	nc.	g, MD 20901
		23a. Part1. Enter the isease, or complice	tions that caused the deat	h. Do not ent	er the mode	of dying,	such as car	rdiac or resp	oratory arres	t,	<u> </u>	Approximate Interval Between
Discontinuo		shock, or heart failure. List only one Immediete Cause (Final	_									Onset and Death
Physician /Medical		disease or condition resulting in death)	Pneumonia Due to (or as a conseq	uence of):								
Examiner												
A	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):								
cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.										
en ar		resulting in death) Last	Due to (or as a conseq	uence of):								
ate be executed hysicien and the burial-transit	Physician/Medical	d.										
leath certifica attending ph	Med	IF FEMALE:										
ath ce	an/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	Ideath 3	Ectopic pre					23d. Date Mor	e of delive oth	ery Day Year
the a	SICI	1 Yes 2 No	4 Pregnant at time of d 9 Unknown	eath 5∟	Other (spe	ecity)						
w requires that the de been signed by the should be detached		Part II. Dther significant conditions contr	ibuting to death but not res	ulting in the u	nderlying ca	use giver	in Part I.	2	3e. Did toba	cco use contri	ibute to th	ne cause of death?
signe d be	1 by	Arrhythmia, Deep Ve			, ,				1 ☐ Yes	2 🗆 No	3 🗍 Prob	abiy 4 🖫 Unknown
requ	etec	12211) 01111124, 2005 10	THE OWNER OF	310				_	4a. Was an	24h W	Vere auto	psy findings available
has law	Completed							- '	autopsy	ed? d	rior to cor eath?	mpletion of cause of
cate									☐ Yes 2	No 1	Yes	2 No
iclan: Th	Be	25. Was case referred to medical examiner?	spital:			Other			ck only one		(0 - 1	
Phys this ral dir	7	1 XYes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time o		^	4 Nursir			ce 6 Othe		//
ding F h. After funer	tlon	1 Natural 5 Pending	(Month, Day Year)	Injury	м	3c. Injury a Work? 1 □ Ye	s 2□No					
Atten deat ctor: y the	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, str	eet, factory,	office					or Rura	I Route Number,
after after d in b	erti	4 Homicide	building, etc. (Specif	у)					ity or Town,	State)		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely fitted in by the funeral director, page 2 should be detached for use as the buriat-transit			cian: To the best of my kno									
n 24 i n 24 i ha Fu	edical	(Check only 2 Medical Examination one)	er: On the basis of examina and manner stated.	uon and/or in				occurred at				
To the To the comp	ž	29b. Signature and title of certifier	0 1 0 0 = 1			License				d. Date signed		
7		Padmaje	S. Udap	1		124	114		J.	an. 2	101	1 .
		30. Name and address of person who com	pleted cause of death (Iter	n 23a) (Type,	Print)							
		Padmaji Udapi M.			#38	0, L	aurel,	MiD	20707			
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	A S	200	Red as	e de la constante de la consta					

			For State Registrar	State of N	Maryland /		artmen <i>tificat</i> e			and Me		iene •g. No. 2 (004	01	606
	Physici		Decedent's Name (First, Middle, Last Margaret Mayer)							2. Date of Dea Month January	Day	Year	3. Time of 10; 3(
	/Medic Examin		4a. Facility Name (If not institution, give Suburban Hospital		or)			Town, or hesd		of Death	,	4c. Count	ty of Death	ry	
la la	Funeral Director		5. Social Security Number 6. Se 100–16–0382	x □ M 2	Age (In yrs. last i	Yrs.	If Under Months	Days	Hours	Min.	B. Date of Birth (Month, Day November			plece (State on intry) ermany	or Foreign
	Maryland 9-f ahow ilied at	tor	10a. State 10b. County Maryland Montgome	ery	10c. City, To Chev				-					10d. Inside C	•
	with the	Direc	10e. Street and Number 8100 Connecticut A	venue #1	222		10f. Zip	Code 0815				Og. Citizen of		•	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants: if item 27 is marked other than "natural", or Items 23a or 28e-f ahow any injury or other treumatic event, the Medical Examinat must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decede Armed Force 1 Yes 23 If Yes, Give Year or Date	nt Ever in U.S. s? ☑ No	1		lent of Hi	spanic Origin, Mexican	gin? (Spec , Puerto R	erty Yes or No- ican, etc.)	14. Ra	ace - Amen ack, White	ican Indian,	
Maryland 21215-0036	within 72 horens. ene. than "nature he Medicul E	ompleted	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-40		(Give	dent's Usua kind of wo. DO NOT us guage	rk done d se retired,	uring most		g	16b. Kind of 1		ndustry	
land 2	uld be filed Aental Hygi rked other itic event, I	To Be C	17. Father's Name (First, Middle, Last) Otto Koch	V					18. Mothe		(First, Middle, ahn	Maiden Suma	me)		
Mary	nd 2 shoulth and N		19a. Informant's Name/Relationship (T) Steven Mayer/ Son	ype, Print)							Route Number e, Minr			55407	7
Baltimore,	Pages 1 ar		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify,		1000.	Wasi	sition (Name to the state of th	ther place LVETS	sity ^J	anuar 200	v 6	20c. Location			
Balti	permit. Departm Importe any inju		21. Signature of Funeral Service Licens	Berd	2-	22	Name an Olumb P.O.	d Addres Dia N Box	s of Facility Iortu 5800	ary S 7 Was	ervice: hingto	s, Inc.	200	37	
8760,	Physician by Specification and	Ilcal Examiner	23a. Pari. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. S Due to (or Due to (or	troke as a consequence as a consequence as a consequence	ce of):	er the mod	e or aying	, such as	cardiac or	respiratory arr	est,		Approximatinterval Bet Onset and 2 Day	ween Death
.O. Box 6	death certif e attending nd for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₩ No 9 □ Unknown		2 ☐ Fetal dea t at time of death		Ectopic pr Other (sp						ate of deliv		Year
Δ.	es ign	þ	Part II. Dther significant conditions co	ntributing to deat	h but not resulting	g in the u	nderlyingc	ause give	n in Part I.			bacco use cor es 2 🗆 No		the cause of c	
I Records,	The ate h page	Completed									24a. Was a autops perfor	ned?	prior to co death?	opsy findings ompletion of c	
Vita	Physicien: The raths certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2♥ No	Hospital:	atient 2 ER/	Outnatier	nt 3 DC	Othe			(Check only or e 5 ☐ Reside		ther (Snec	ih/)	
ion of	of the state	-	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of I (Month,		o. Time o Injury		8c. injury Work		28	Bd. Describe h			1197	
Division	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building.	Injury - At home, etc. (Specify)	, farm, str	eet, factory	, office		28	Bf. Location (S City or Town		ber or Rur	ral Route Nurr	nber,
	e Hospi 24 hou ie Funei letely fill	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medicel Examone)		s of examination										s)
)	To th withir To th comp	Me	29b. Signature and title of certifier	Q9	1110	2	290	D05	number 9303		2	9d. Date sign Januar			
			30. Name and address of person who o	//				eorc	retowr	n Rd.	Bethes	sda, MD	208	314	
	Sta Regist		31. Date filed (Month, Day, Year) JAN 09 20		istrar's Signature			nkr				,			

			110000	State of Marylai			of Healt		•	aiene	e	
		•	For State Registrar	Otato of Maryta			of Dea				2004	01607
			Decedent's Name (First, Middle, Las	()					2. Date of De			3. Time of Death
	Physici /Medi Examir	al	Dorothy May McAdams January 1,					1,	2004 County of Deat	5:42 P M		
			Holy Cross Hospi		Anna Charles	Silve	r Spri	ng	0 O-11 Bis		ontgomer	
jaz.	Funeral Director		219-12-2976	7. Age (In yrs	Vre	Months			8. Date of Bir (Month, Da April	y, Year)		hplece (State or Foreign untry) ryland
	land w	by Funeral Director	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or L	ocation				<u> </u>		10d. Inside City Limits
Maryland 21215-0036	he Mary 28a-f eh		Maryland Montg	omery	Silve	r Spri	ng			10a Cit	tizen of What Co	1 ☐ Yes 2 承No
	h with t		321 University B1	vd West #1	12	TOT. ZIP C	2090	1		_	ISA.	uriti y r
	J within 72 hours after death with the Maryland jiene. r than "naturel", or tems 23a or 28a-f ehow the Musical Esaminetroual by motified at		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:				c Origin? (Spe xican, Puerto	cify Yes or No Rican, etc.)		14. Race - Ame Black, Whit Specify:	e, etc.
			15. Decedent's Ed (Specify only highest grad	ucation	(Give	dent's Usual	done during	most of worki	ng	16b. K	ind of Business/	lite Industry
		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		<i>DO NOT ú</i> se emaker				0-	II	
d 2	e filed al Hygi other	BeC	17. Father's Name (First, Middle, Last)		TOIL	emaker		fother's Name	(First, Middle		vn Home Sumame)	
ylaı	ould b Ment Merked Marked	To	Worthy Sanders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cit									
Mar	d 2 sho th and ! !? ie mu trauma	71	19a. Informant's Name/Relationship (7									
d)	es 1 and 2 should be filed of Health and Mental Hygis filem 27 is marked other r other traumatic event, II	1 8	Francis J. McAdams, Jr. Husband 321 University Blvd. West #112 Silver Spring, MI) 20a. Method of Disposition 20a. Method of Disposition 20b. Place of Disposition (Name of cemetary or other place) 3 Removal from State Cate of Heaven									
Baltimore,	Page ment ant: E ant.		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	7	C	emeter	y	Jan.5	,2004	Silv	er Spri	ng,Maryland
Ball	permit. Pages 'Department of Himportant: If ite ony injury or of page.	1	21. Signature of Funeral Service Licen	S99							ne, Inc.	
	4		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause of each line. 1500 University Blvd., W., Silver Spring, MD 20901 Approximate Interval Between									
H	Physician		Immediate Cause (Final disease or condition a Cardiac Arrest								Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a conse								
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Sepsis Due to (or as a consequence of):								
,760,	ite be executed ysician and ne burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Pn mon 1. Due to (or as a conse	quence of):							
9	ntificat ng phy s as th		IF FEMALE:					-	-0K		Ĭ	
.O. Box	it the death certificat by the attending phy tached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	⊒Ectopic pre ⊒ Other (spe					23d. Date of del Month	ivery Day Year
Ω.	s that t ned by e deta	by Ph	Part II. Other significant conditions of	ontributing to death but not re	sulting in the o	inderlying ca	use given in P	Part I.	23e. Did t	obacco (use contribute to	the cause of death?
ords	The law requires that the death certifica tale has been signed by the attending pheage 2 should be detached for use as the	Medical Certification: To Be Completed b	Cervical Cancer					Yes 2	2 No 3 Probably 4 Dunknown			
Records,			Heart Failure								prior to death?	itopsy findings available completion of cause of 2 No
Vital			25. Was case referred to medical examiner?	Manitali				Place of Death	(Check only o			
of	ng Phys fter this meral di		1 ☐ Yes 2 ☒ No 27. Manner of Death					-	Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			
			1 ▼Natural 5 Pending 2 Accident investigation	(<i>Month, Day</i> Yea <i>r)</i> Injury Work? on M 1 ☐ Yes 2 ☐ No								
Division	al or Atte s after de if Directo id in by th		3 Suicide 6 Could not be determined					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
											stated. to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifier	11		29c.	License numl	_		29d. Da	te signed (Mont	h, Dey, Year)
	2		1 Catt	Mn	/		00	591	21	1/	4015	
	•		30. Name and address of person who				n 1 -	0.11	a .			00010
-	St	ate	Catherine Godfrey 31. Date filed (Month, Day, Year)	32. Registrar's Sigr	rorest		Road S	Silver	Spring	, Ma	ryland	20910
	Regist		TAN 0 6 20	MA Denava	D	200	und					

		At:	1 - For State of N	laryland / Depa	artment of F		Mental Hy	/giene 2 (01608	
	Physic	ian	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Yeer							
	/Medi		Robert Joseph McCarthy Januar						04 5:15 A M	
4	Exami	ner	4a. Facility Name (If not institution, give street and numbe		or Location of Death	1	4c. County			
	Function		Suburban Hospital 5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday)	Bethesd If Under 1 Year	a. If Under 24 Hrs.	8. Date of B	Montg		
	Funeral Director		136-32-3102 1\(\overline{\text{X}}\) M 2□F	89 Yrs.	Months Days	Hours Min.	(Month, D	ay, Year) 1914	9. Birthplace (State or Foreign Country) New Jersey	
	D		Usual Residence of Decedent		1		Joans C	- 1714		
	arylar ehow	Funeral Director	10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits	
	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23a or 28a-1 show other traumatic event, the Medical Exercipal marked by notified at		Maryland Montgomery 10e. Street and Number	Bethesda					1 ☐ Yes 2X No	
		Ö	106. Street and Number 106. Zip Code 10g. Citizen of What Country 6011 Kingsford Court 20817 United States							
Maryland 21215-0036		era	6011 Kingsford Court 20817 United St. 11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Hamed Forces? 14. Race - Amed Forces? 15. Was Decedent of Hispanic Origin? (Specify Yes or No-Hamed Forces) 14. Race - Amed Forces? 15. Was Decedent of Hispanic Origin? (Specify Yes or No-Hamed Forces) 16. Was Decedent of Hispanic Origin? (Specify Yes or No-Hamed Forces) 17. Was Decedent Ever in U.S. 18. Was Decedent of Hispanic Origin? (Specify Yes or No-Hamed Forces) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-Hamed Forces) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-Hamed Forces) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-Hamed Forces) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-Hamed Forces) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-Hamed Forces) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-Hamed Forces) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-Hamed Forces) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-Hamed Forces) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-Hamed Forces) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-Hamed Forces) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-Hamed Forces) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-Hamed Forces) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-Hamed Forces) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-Hamed Forces) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-Hamed Forces) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-Hamed Forces) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-Hamed Forces) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-Hamed Forces) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-Hamed Forces) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-Hamed Forces) 18. Was Decedent Origin (Specify Yes or No-Hamed Forces) 18. Was Decedent Origin (Specify Yes or No-Hamed Forces) 18.						States - American Indian,	
		F	Armed Forces	1? 1 No			Rican, etc.)	Bla	ck, White, etc.	
		by	3 ♥ Widowed 4 □ Divorced If Yes, Give Year or Dates	:WWII	1 ☐ Yes 2🌠 No	Specify:		Specif	y: White	
5-0		Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup	during most of wor.	kina	16b. Kind of B	usiness/Industry	
121	vithin hen hen	mpi	Elementary/Secondary (0-12) College (1-4o	5+) life.	DO NOT use retire	d)				
2	2 should be filed within and Mental Hygiene. is marked other than "aumatic event, the Me.	ပိ	17. Father's Name (First, Middle, Last)	Physi	cian	18. Mother's Nam	o /First Middle	Medica		
ano		To Be	Robert McCarthy			Sarah Mu		a, maiden Surnan	пну	
<u></u>	Shoul nd Me mark	Ĕ	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	and Number or Ru		er. City or Town.	State. Zin Code)	
	and 2 saith a n 27 is		Michael E. McCarthy/Son			Court, D				
ē,	s 1 a of Hez		20a. Method of Disposition	20b. Place of Dispo	sition (Name of natory or other place	Janus	Date 21,		City or Town, Stete	
E	Pages nent of int: If it		1 XBurial 2 ☐ Cremation 3 ☐ Removal from Stat '4 ☐ Donation 5 ☐ Other (Specify)	Arlington Cemete	Nationa		•	Arlingt	on, Virginia	
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 eny injury or other tr 900.		21. Signature of Funeral Service Licensee	M01346 Be	Name and Addre thesda-Cl thesda, I			Pumphrey 7557 W:	y Funeral Home/ isconsin Avenue	
	eath certificate be executed Wedical attending physician and for use as the burial-transit		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	ed the death. Do not ent					Approximate Interval Between	
			Immediate Course /Circl	cular Fibri	llation				Onset and Death Minutes	
į,			resulting in death)	s a consequence of):					Himacos	
		L	Sequentially list conditions, b. Athero	sclerotic C	oronary A	Artery Di	sease		Years	
		al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		•					
_			that initiated events resulting in death) Last C. Dyslipidemia Due to (or as a consequence of):					Years		
8760,			j Substitution as a consequence of).							
687	ficate physis the	edic	d							
Вох	certii nding use a	n/M	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant					23d. Da	te of delivery	
	death e atte	by Physician/Medical	in the past 12 months? 1 Yes 2 No. 4 Pregnant at time of death 5 Other (specify)						nth Day Year	
P.0	Attending Physician: The law requires that the death certificate be executed redeath. "death," redeath exertificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit		9 ☐ Unknown							
			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						acco use contribute to the cause of death?	
ord		ted	Thrombocytopenia					Yes 2□No	es 2 □ No 3 □ Probably 4 ☑ Unknown	
ecc		Completed					24a. Was		Were autopsy findings available prior to completion of cause of	
= H		Son					perfo 1 ☐ Yes	ormed?	death? I □ Yes 2 □ No	
Vital Records,	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?			26. Place of Deal	h (Check only	one)		
of	* Attending Physier death. rector: After this c by the funeral dire	၉	1 ☐ Yes 2 🛣 No Hospital: 1 🛣 Inpat			4 Nuising no	ome 5 Residence 6 Other (Specify)			
Division o		ion	1 XNatural 5 ☐ Pending (Month, D	ury 28b. Time of Injury	28c. Injun Worl M 1		28d. Describe how injury occurred			
		Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Ir	1 Yes 2 No			or or Pural Pouto Number			
Θ	after after Dire	ertii	4 Homicide determined 206. Place of if building, a	lace of Injury - At home, farm, street, factory, office uilding, etc. (Specify)				 Location (Street and Number or Rural Route Number, City or Town, State) 		
	apita hours naral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	To the Hospital or Attentwithin 24 hours after deatl To the Funaral Director: completely filled in by the	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	To the within To the Comp	Me	29b. Signature and title of certifier		29c. License	a number		29d. Date signed	(Month, Day, Year)	
)	. LI) (Catson	_	40.	576		January	4, 2004	
3	0		30. Name and address of person who completed cause of		•					
	(10)		Ramin Roskovi, M.D. 3301 New Mexico Ave. N.W. Suite 202, Washington, D.C. 20016							
	Sta Registi			rar's Signature	Sparks					
	negisti	ai .	JAN 0 6 2004		1 1					

Mccorthy, Robert, J. DR. 1/4/04 515AM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Loc 4 0535 AM **Physician** MALY MEMMO ANGELA favorde-/Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Marteomery BUNHERON SUBUREAN HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🔼 F 50 31, 1953 West Virginia 217-70-4441 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Importment If item 27 is marked other than "natural; or items 23s or 28s-f show smyoring or other traumatic avent, the Medical Examinat must be redifficed an once. 10a State 10b. County 1 ☐ Yes 2 ☑ No Director Maryland | Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5306 Flanders Avenue 20895 by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🖾 No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Montgomery County Public Schools College (1-4or 5+) Elementary/Secondary (0-12) 12 Special Education Bus Attendant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Samuel Peter Memmo Yolanda F. Goffredo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yolanda F. Memmo/ Mother 5306 Flanders Avenue, Kensington, MD 20895 Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place)
Gate of Heaven
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition January 6 1 XBurial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 2004 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licenses 500 University Blvd. W., Silver Spring, MD 20901 EUMO 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Anterioscusporio CARDIOVASCUAL DISEASE **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events byrial-trai resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, edicai IF FEMALE ian/M use Or 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year ō in the past 12 months? Month Day Physicia 5 Other (specify) bed 9 Unknown detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P HYREACHOLESIE ROLEMIN . 1 Yes 2 No 3 Probably 4 Whitenown MEXICATIFORTY ted 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe pane 2 X No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 86 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ★ R/Outpatient 3 ☐ DOA 1 ∑Yes 2 ☐ No ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Accident 5 Pending investigation 1 Yes 2 No hours after deat 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide and the second Of PLIGhe Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 豪 24 within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JANUAY 3,2004 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOOKILLE, MO LOSSA CHAL I' MYROOUS 1116 Pagerille 31. Date filed (Month, Day, Year) JAN 0 6 32. Registrar's Signature State Registrar

1	For State Registrar	State	of Maryla	and / Depa <i>Cei</i>	artment of F tificate of I	lealth and Death	Mental Hy	giene Reg. No.	2004	016	10
	. Decedent's Name (First, Middle	Last)					2. Date of De	ath Day	Vone	3. Time of D	eath
nysician Medical —	Leonarda R. M	ercado					Januar		2004	2:20	ам
xaminer 4	a. Facility Name (If not institution,	give street and n	umber)		4b. City, Town, or	r Location of De			County of Death		
	Suburban Hosp	ital			Bethes			M	ontgomer	У	
ierai	,	6. Sex 1 ☐ M 2 🔼 F		rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hi		h y, Year)	9. Birthp	lace (State or I	Foreign
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	sual Residence of Decedent 0a. State 10b. County		10c.	City, Town or Lo	cation				1	0d. Inside City	Limits
5 7	Maryland Monte	O O 2477	_	·)1! 1 1						1 ☐ Yes 2	
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10	3 Arlive Cou	de				,				y.	
Funeral	1. Marital Status	12. Was De	cedent Ever in	U.S. 13.1	20854 Was Decedent of H	ispanic Origin?	(Specify Yes or No	US	SA 14. Race - Americ	an Indian.	
	1 Never Married 2 Marrie		2 X No		Yes, specify Cuba	in, Mexican, Pue	erto Rican, etc.)		Black, White,	etc.	
by	3 Widowed 4 Divorced	If Yes, G Year or			I⊠ Yes 2□ No	Specify: Pt	u ert o Ric	an	Specify: Whit	e	
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e 1	7. Father's Name (First, Middle, L					18. Mother's N	ame (First, Middle,	Maiden S	Sumame)		
2	Jose Antonio		.ez				ina Iriz				
	9a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	g Address (Street a	and Number or F	Rural Route Numbe	r, City or	Town, State, Zip	Code)	
-	Iris Mercado F	enton/ D		n 3 A	rlive Cour	rt, Rock	cville, M		0654		
7	0a. Method of Disposition	3 □Removal from	n State	cemetery, crer	natory or other plac	_{:e)} і Ла	nuary 7	20c. Loc	cation - City or To	wn, State	
	* 4 ☐ Donation 5 ☐ Other (Sp		0	Gate of Cemet			2004	Sil	ver Spr	in, MD	
	1. Signature of Funeral Service L	icensee	20	22 F-	. Name and Addres	ss of Facility	s Funeral	Цот	o Tmo	100	
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ğ	art II. Other significant condition Diabetes Mellit		death but not r	esulting in the ur	iderlying cause give	en in Part I.	T .		se contribute to th		
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Completed							autop perfor 1 Yes	med?	24b. Were autop prior to con death? 1 Yes		se of
0 Be	5. Was case referred to medical examiner?	Hospital:		7//	Othe		eath (Check only or				
F +	1 ☐ Yes 2 ☒ No 7. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date (Mo		28b. Time of Injury	28c. Injury Work	at Nursing	Home 5 Resid)	
Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ned 286. Plac	ce of Injury - At ding, etc. (Spe	t home, farm, streetly)	eet, factory, office		28f. Location (S City or Tow	treet and n, State)	Number or Rural	Route Number	r.
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	9b. Signature and title of certifier			-	29c. License	number	2	9d. Date	signed (Month, L	Day, Year)	
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3	0. Name and addres elerson w	no completed cau	use of death (li		•						
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State ³	1. Date filed (Month, Day, Year)	004	Registrar's Sig	nature &	Sports	/					

			1 - For State Registrar				nd / Depa		of He	ealth a	ind M		jiene	200		01611
	Physic /Medi Examir	cal	Decedent's Name (First, Mid-Marianne M Aa. Fecility Name (If not institut. Suburban Hosp	esseng		ber)	1.	4b. City, T	own, or these			2. Date of Dea Month January	Day 4	2004 County of I	Deeth	3. Time of Death 12:00 PM
	Funeral Director		5. Social Security Number 209-38-7958 Usual Residence of Decedent	6. Sex 1 ☐ M	2(X)F	7. Age (In yrs. 57	last birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day June 28	, Year)	46		ace (State or Foreign y) PA
	within 72 hours after death with the Maryland ene. then "natural", or Items 23a or 33a-1 ehow he Marical Expanding Land be defilied at	ector	10a. State 10b. Coun MD Mont 10e. Street and Number	gomery	7	10c. C	ity, Town or Lo			lontg	omery	y Villa				d. fnside City Limits 1 X Yes 2 □ No
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3036	nours after our iter	Ď	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 🔀 Divorce	rried	Armed Ford 1 Yes 2 If Yes, Give Year or Date	es? 2 M No		Yes, specif		Mexican, Specify:	Puerto P	cify Yes or No- lican, etc.)		Black, V	Vhite, et	
21215-0036	be filed within 72 hours after death with the Marylar lal Hygiene. d other then "natural", or flems 23s or 32s-1 show event, the Marical Expuner man be political at	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)		conpleted) Coltege (1-5+	4or 5+)	16a. Deced (Give life. L	lent's Usual kind of work OO NOT use Art	done du retired)	ring most	of workin	g		nd of Busin		stry School
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	1D		1 Juten	4/	TE		60	O		7.7	5	25	/- S	signed (Mo	Juniti, Da	y, rear)
	Sta	te	30. Name and address of person Frederick G. B 31. Date filed (Month, Day, Year	arr, l	M.D.,		Medical	Park		ze,#2	01,	Silver	Spr	ing, l	1D 2	0902
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			1 - For State Registrar	State of M		/ Depa		of H	ealth a		-		2001	. 11	612
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	Physici /Medio		Pauline N.	Miller							January		2004	8:45	P^{M}
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	land		10a. State 10b. County		10c. City, T	own or Lo	ocation							10d. Inside Ci	ty Limits
	Mary Interp	to	Maryland Montgom	ery	Gait	hersl	burg							1 X Yes	2 🗌 No
	r 28a	Directo	10e. Street and Number		1		10f. Zip	Code				10g. Citiz	en of What Co	untry?	
	th wit	aiD	415 Russell Ave	nue #213			208	377				Unit	ed Stat	tes	
	ema ema	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Deced	ent of Hi	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)	- 1	4. Race - Ame Black, White		_
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8	d within 72 hours after death with the Maryland jene. r than "natural", or flema 23a or 28e-f show the Medical Exacinet must be notified at	ed b	15. Decedent's 8	Year or Dates:	1	6a Dece	dent's Heua	Occupa	ition			16h Kin	d of Business/	Industry	
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	/Medical		disease or condition resulting in death)	Due to (or as	a consequen	ce ol):	> ' \		,					24 h	'A.7
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Division	or Attendate death Director: in by the	Certification:	4 Homicide determine			, Jarm, Str	eet, lactory,	office		2	City or Tou		Number of Hu	ral Route Numi	oer,
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7	0		30. Name and address of person who		eath (Item 23	a) (Type,	Print)		- 1	19	901M -	1 . t =	((-	ala B	0850
			Isobelle Her	7	Sha	dy	2000	He	os pri re	-17	Zochi	والراقة	- ME	zry lan	el el
- 125	Sta Registr		31. Date liled (Month, Day, Year) JAN 0 7 2		ar's Signature	15	do	de	1		901Mec Zoch			4	

			For State Registrar	State of Maryland / Dep. <i>Ce</i>	artment of Health and fi rtificate of Death		ene 200	01613
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	/Medi		Rachel Long	Misey		January	3, 2004°	12:05MM
	Examir	ner	4a. Fecility Name (If not institution, give		4b. City, Town, or Location of Death	1	4c. County of Dear	
	5		Suburban Hospita 5. Social Security Number 6. Se		Bethesda If Under 1 Year If Under 24 Hrs.	8 Date of Birth	Montgome	
	Funeral Director			☐M 2점F 79 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y) Feb. 4,		hplece (State or Foreign Juntry) 1ahoma
	within 72 hours after death with the Maryland ene. than "netural", or Items 23s or 28s-f show the Modical Exertiret mast be notified at	tor	10a. State 10b. County Maryland Montgome	10c. City, Town or Lo				10d. Inside City Limits 1
	with the 3a or 28	1 Direc	10e. Street and Number 11410 Strand Drive	•	10f. Zip Code 20852		. Citizen of What Co	•
	death ms 2	era	11. Marital Status		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		ited Stat	
030	al', or ite	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 TxNo	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 XNo Specify:	Rican, etc.)	Black, White Specify: White	e, etc.
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<u> </u>	e filed of the vent,	e C	17. Father's Name (First, Middle, Last)			e (First, Middle, Ma		IDIALY
<u> a</u>	old b Aenta rked	0	Clarence Long		Odie Mc	Laughlin		
ге, магу	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiens. Important: If tiem 27 is marked other than "naturat", or Items 23a or 28a-1 show any injury or other traumatic avent, the Modical Examinet must be notified at once.		19a. Informant's Name/Relationship (7) Johanna Misey Boye 20a. Method of Disposition	er/Daughter 702 T	ng Address (Street and Number or Rui Win Holly Lane, S	al Route Number, C		land 20910-
baltimore,	epartment of opportunit. If in your injury or nes.		1 ☐ Burial 2 【②Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service License)	Cremater Cremater	mery ium, Inc. 6, 2	004 Her	thesda. Ma	
<u>.</u>	205 20		THY YORK	HOTSO BE	etnesda, Maryland	20814-350	1	
	Physician /Medical Examiner		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the death. Do not ent ne cause on each line. a. Subarachnoid H Due to (or as a consequence of):		or respiratory arrest,		Approximate Interval Between Onset and Death
	uted i insit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):				
,007	icate be executed physicien and s the burial-transit	cai	that initiated events resulting in death) Last	Due to (or as a consequence of):				
	death certif e attending od for use a	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 StNo	4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delin	very Day Year
5	at the de by the	hys	9 🗌 Unknown	9□ Unknown				
600	law requires that the as been signed by th 2 should be detache	ed by PI	Part II. Other significant conditions co	ntributing to death but not resulting in the ur	nderlying cause given in Part I.		co use contribute to 2 □ No 3 □ Pro	the cause of death? bably 4 (XUnknown
٠,	ate h page	Completed				24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
AII	certificate	Be	25. Was case referred to medical examiner?			(Check only one)		
5 8	rnysician: this certific ral director,	은	1 ☐ Yes 2 ☐ No	Hospital: 1 XInpatient 2 ☐ ER/Outpatien		me 5 🗌 Residence	e 6 □Other (Speci	(h)
	After fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how i	njury occurred	
			3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)		City or Town, Si	·	,
	no the hospital or within 24 hours after To the Funeral Dis completely filled in	Medical	one) 2 Medical Exemi	sician: To the best of my knowledge, death ner: On the basis of examination and/or inv and manner stated.	n occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as and place, and due to	stated. o the cause(s)
	Con	2	29b. Signature and title of certifier	Varieti 1	29c. License number DO 21781		Date signed (Month,	Day, Year)
	(-		/1.8	empleted cause of eath (em 23a) (Type, I	,			
	Sta	te	John /W. Barrett, 31. Date filed (Month, Day, Year)	M.D. 4927 Auburn A	venue, #200 Bethe	esda, Mary	land 208	14

			1 - For Stete Registrar	State of M	Maryland /	-	artment of I				giene 2	004	O metan	614
			1. Decedent's Name (First, Middle, Last)							2. Date of Dea Month	ith Day	Year	3. Time of	Death
	Physici /Medio		Janet G. Montgo	mery						January			6:15	ам
	Examin		4a. Facility Name (If not institution, give	street and number	or)		4b. City, Town,	or Location	of Death		4c. Coun	ty of Death		
			Suburban Hospit	al			Bethes				Mont	tgomer	У	
	Funeral		Social Security Number 6. Security Number	7. / M 2DXF	Age (In yrs. last		If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birth	olace (Stete o ntry)	r Foreign
	Director		5/9-62-4315	1 W1 2 (23.1	55	Yrs.				June 9,	1948	Wash	ington	, DC
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation						10d. Inside Ci	ty Limits
	Aaryl:	ō			0.11		C 1						1 🗌 Yes	2 🙀 No
	28a-	ect	Maryland Montgon 10e. Street and Number	егу	511	ver	Spring 10f. Zip Code			1	10g. Citizen o	f What Cou	ntry?	
	with a or		2826 Hardy Avenue				2090	12			USA		,	
	ns 23	era		12. Was Deceder		13. \	Was Decedent of f Yes, specify Cut		igin? (Spe	ecify Yes or No-		ace - Ameri		
(0	r Her	Funeral Director	1 ☐ Never Married 2 ☐ Married	Armed Force						Rican, etc.)		lack, White,		
03	al', o	Ď	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Date:	s:		1 □ Yes 2 🖾 No	Specify:			Spec	ity: Whi	te	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ahow ita Madical Exertirer must be notified at	Completed	15. Decedent's Edu (Specify only highest grad		16	(Give	lent's Usual Occu	durina mos	t of worki	na	16b. Kind of	Business/In	dustry	
2	ithin	nple	Elementary/Secondary (0-12)	College (1-40	or 5+)		DO NOT use retire	ed)						
2	filed w Hygier Sther th	S	12			Hon	nemaker	10 Moth	ada Nama	/First Adjustes		wn Hor	ne	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Exertifier must be notified at	Be	17. Father's Name (First, Middle, Last)							(First, Middle,	мөшөп эшт	ame)		
S	should be tand Mental s marked o	2	Joseph Worth I			Ob Mailia	a Address (Street			Johnson	c City or Tow	m Stata Tir	Code)	
Mai	12 st h and 7 is n traun		19a. Informant's Name/Relationship (Ty				g Address (Stree							
	permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tra once.		Michelle J. Lane/ 20a. Method of Disposition	Daugnte	20b, Place	of Dispo	Hardy A			lver Spi	rin. 20c. Location			
Baltimore,	Pages nent of linut: If its		1 ⊠ Burial 2 ☐ Cremation 3 ☐ F	emoval from Sta	te ceme	itery, crer	natory or other pla		Janua	ry 12				
ĦΞ	riant mer		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Ligens		Fort		In Cemet . Name and Addr	The second second		.004	Brent	wood,	Mary1	and
Bal	permit. Pages Department of Important: If i any injury or		23 compt	lins Blvd	Funeral . W., S		Inc. Sprin	_						
г			23a. Part1. Softer the disease, or compleshock, of heart failure. List only or	cardiac c	or respiratory arr	rest,		Approximate Interval Bette Onset and I	ween					
	Physician		Immediate Cause (Final disease or condition		8	EP	515						Oriset and t	Jealii
10	/Medical Examiner		resulting in death)	Due to (or a	as a consequenc	ce of):								
	LAdillilei	_	Sequentially list conditions,)										
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consequent	se oi):						- 11		
	and and II-trar	Examiner	that initiated events resulting in death) Last	Due to (or a	as a consequenc	ce of):								
8760,	ate be executed hysician and the burial-transit													
687	ficate phys s the	adic												
Box (The law requires that the death certificate be executed tae been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcon							23d. E	Date of delive	ery	
m	death a atter	ciai	in the past 12 months?	4 Pregnant	2 Fetal dea at time of death		Ectopic pregnand Other (specify) _	су			N	Month	Day \	/ear
0	that the dead by the detached	hys	9 □ Unknown	9□ Unknowr	1					-				
Θ,	res that igned b	by P	Part II. Other significant conditions con	ntributing to death	but not resulting	g in the u	nderlying cause g	ven in Part I		23e. Did to	bacco use co	ntribute to t	he cause of d	eath?
ğ	w require been sig should b	ed t								1 🗆 Y	es 2 1 No	3 Prob	oably 4 □U	Inknown
Records,	aw requ s been 2 shouk	Completed								24a. Was a autops		. Were auto	psy findings mpletion of c	available
Re	The lay te has	mo								perfor		death?	2É⊉ŕÑo	ause of
Vital	ician: Th certificate rector, pag	a	25. Was case referred to medical					26. Place	of Death	(Check only or				
f <	Physician: r this certificatal director.	To B	examiner? 1 Yes 2 No	lospital: Mnpa	atient 2 ER/	Outpatien	t 3 DOA	her: 4 🗆 Nu	ursing Ho	me 5 Reside	ence 6 🗆 O	ther (Specif	y)	
Jo u			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Ir (Month, I	njury 28t	b. Time of	28c. Inju	iry at		28d. Describe h	ow injury occi	urred		
Si Ois	Attending r death. ector: After y the fune	atic	2 Accident investigation				M 1	Yes 2 🗆	No					
Division	or Att	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building,	Injury - At home, etc. (Specify)	, farm, str	eet, factory, office		1	28f. Location (S. City or Town		nber or Rura	al Route Num	ber,
	urs af													
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medical Exami one)		of examination)
	To the To the Complex	Ž	29b. Signature and title of certifier	0				se number			29d. Date sign			
•	Oj		1 Cm	120	is, n	21)	00	200	712	24	11	710	4	
	1,-		30. Name and address of person who co	ompleted cause o	of death (Item 23	а) (Туре,	Print)							
			Truong Bao M.D 1				10		manto	wn, MD	20879			
	Sta		31. Date filed (Month, Day, Year)	32. Degi	strar's Signature	B	Spark	1						
*	Regist	rar	JAN 09 200	4 /4			//							

MONTGO MERY, SANET

			1 - For Stete Registrar	State of Ma		partmen ertificat				giene Reg. No.	004	01615
П	Physic	ian	Decedent's Name (First, Middle, Las						2. Date of Dea Month	th Day	Year	3. Time of Death
	. /Medi	cal	Frank Ton 4a. Facility Name (If not institution, give	1		4h Cih.	Town as La		Jan.2			1:41p M
1	Examii	ner	Holy Cross Hos					ocation of Death			nty of Death	
	Funeral		5. Social Security Number 6. Se		(In yrs. last birthd	ay) If Under	1 Year	Sprin f Under 24 Hrs.		MOT	1tgom 9. Birthp	ery place (State or Foreign ntry)
	Director		339-22-4219	ØM 2□F	81 Yrs	Months .	Days	Hours Min.	1/12/	, Year) 1922	Chi	ntry)
	nd *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location						
	faryla shor	ō	Md Montgom	ery		er Sp	rina				'	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the A 28e-1	ect	10e. Street and Number			10f. Zip				l0g. Citizen o	of Minat Cour	
	death with the Maryland rms 23e or 28e-f show rmst be notified at	Ö	802 Wayne Avenu	е			2091(0		USA	T TTIAL COU	my:
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiens. Importent: If item 27 is marked other than "naturel", or Items 23e or 28e-f show any injury or other treumatic event, the Maulical Evantmer must be notified at DDGs.	Funeral Director	11. Marital Status	12. Was Decedent E	ver in U.S. 1	3. Was Deced	lent of Hispa	anic Origin? (Sp	ecify Yes or No- Rican, etc.)		ace - Americ	
9	after or Ite		1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☐ Yes 2 ∑N If Yes, Give	0	1 Yes		mexican, Puenc Specify:	Hican, etc.)		fack, White,	
8	72 hours after naturel', or Ite	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		10 163	٠ ١١١٠ ليط	эрөспу.		Spec	ify: Asi	.an
15	n 72 t	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)	16a. De	cedent's Usua	Il Occupation de de la companie de l	on ing most of work	ring	16b. Kind of	Business/Ind	dustry
21215-0036	within lene. then "	m d	Elementary/Secondary (0-12)	College (1-4or 5-	-)	elf e				T a	l /D	
	Hyg Hyg other	Ö	17. Father's Name (First, Middle, Last)			CII CI			e (First, Middle,			ry Cleane
Maryland	ould be Menta! Marked o	To Be	Willie Moy					Kee Ho	Chin			
ar	and h		19a. Informant's Name/Relationship (T	ype, Print)	19b. Ma	ailing Address	(Street and		al Route Number	; City or Tow	n, State, Zip	Code)
	and and and m 27 m 27 mer tr		Louise Moy Shu/	Daughter	34	12_Gl	enmoc	or Dr.	Chevy_	Chase	, Md 2	20815
Baltimore,	M ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ I	Removal from State	20b. Place of Dis	sposition (Nan rematory or o	ne of ther place)			20c. Location		
Ē	G in the D		`4 □Donation 5 □ Other (Specify))	Chesap	eake	Crem	. 1/04	/04 E	Belts	ville	.Md
ga Ba	permit. Departr Importe any inju		21. Signature of Funeral Service Licens	97/		22. Name and PHILII	d Address o	of Facility				E, P.A. Ma20910
	Interiaw requires that the death certificate be executed X	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (classes or injury	a. Pneur Due to (or as a Due to (or as a	CONIA consequence of):	enter the mode	e of dying, s	such as cardiac	or respiratory arm	est,		Approximate Interval Between Onset and Death
P.O. Box 6	it the death certifics by the attending pt tached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetel death	3 □Ectopic pre 5 □ Other (spe					ate of delive	ry Day Year
of Vital Records, P	equires that ten signed bould be det	þ	Part II. Other significant conditions co.	ntributing to death but	not resulting in the	underlying ca	iuse given ii	n Part I.				e cause of death? ably 4 □Unknown
ပ္က	e law requii has been s je 2 should	Completed							24a. Was a	n 24b.	Were autop	osy findings available
ř	ate ha	E							autops perform 1 Yes 2	ned?	death?	npletion of cause of 2 No
īa	certificate rector, pag	Be	25. Was case referred to medical examiner?				26	3. Place of Deatl	Check only on			
2	rnysicien: this certifica ral director,	욘	1 ☐ Yes 2 🔀 No	lospital: 1 ☑ Inpatien					me 5 Reside	nce 6 □Ot	her (Specify,)
ב	After After funera	on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Ye <i>ar)</i> 28b. Time		c. Injury at Work?		28d. Describe ho	w injury occu	rred	
200	Attending r death. sctor: After by the funer	Certification;	2 Accident investigation 3 Suicide 6 Could not be	One Place of Injur	At home from	M		2 □No	201 1 101			
= 8	i Digital	ertif	4 Homicide determined	28e. Place of Injur building, etc.	(Specify)	street, tactory,	office		28f. Location (Sti City or Town	eet and Num , State)	ber or Hurai	Houte Number,
3	A hours Funerel	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sicien: To the best of ner: On the basis of e and manner state	xamination and/or	ath occurred a investigation,	it the time, o	date and place, on, death occurr	and due to the ca ed at the time, da	use(s) and m ite and place,	anner as sta , and due to	ated. the cause(s)
1	vithin 24 h To the Fur	Me	29b. Signature and title of certifier	10.		. 29c.	License nu	ımber	29	d. Date signe	ed (Month, D	Day, Year)
N. 1			Daima	Ma	was	\sim	D000	58965		1/02	2/04	
	P		30. Name and address of person who co	ompleted cause of dea	ath (Item 28a) Typ					., 02	-, 0 1	
			Khawaja Saima M	I.D. 1500	Forest	Glen	_Rd_	Silve	r Sprir	1. N		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	s Signature		uls.		PI 11	·9,Md		-
	Registr	ar	JAN 0 6 200	14 June	N	japo	CAO!					

			State of Maryland			•	~	
		1 - For State Registrar	olato of marytana /		ate of Death	Reg.	711111	+ 0161
Physic /Med		Decedent's Name (First, Middle, Last VI PN	Nick			2. Date of Death	Day Yeer 5 20	
Exami		4a. Fecility Name (If not institution, give	street and number)	4b. 0	ity, Town, or Location of De	ath	4c. County of De	
Funeral Director		Anne Arundel M. 5. Social Security Number 6. Se	edical Center × □M 2덨F 75	t birthday) Trur Yrs. Mont	na Days Hours M	n. 8. Date of Birth (Month, Day, Ye		rthplace (State or Foreig Country)
pug *		Usuel Residence of Decedent 10a. State 10b. County		own or Location		OCL. 7. I	928 Mar	
th the Maryli or 28a-f sho	Director	Maryland Anne A:		y Side	Zip Code	10g.	Citizen of What C	10d. Inside City Limit 1 ☑ Yes 2 ☐ No
Z 15-UU36 hin 72 hours after death with the Maryland e e "natural", or Items 23e or 28e-f show Medical Examirer must be redified at	Funerai	1421 Shady Res	Road 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No	13. Was De	20764 cedent of Hispanic Origin? specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	USA 14. Race - Am Black, Whi	
Z I Z I 3-UU36 d within 72 hours alt giene: griden "natural; or the wedical Eram	þ	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu	If Yes, Give Year or Dates:	6a. Decedent's U	s 2 \ No Specify:	16h	Specify: Kind of Business	Black
within ane. then	Completed	(Specify only highest grad	completed) College (1-4or 5+)	(Give kind of life. DO NO	work done during most of w Tuse retired)	rorking	Kind of Dusiness	vindustry
be file tat Hy d oth	Be	11 th 17. Father's Name (First, Middle, Last)	0	Se		ame (First, Middle, Maid	en Sumame)	tor Tour
2 should and Men is marke	7	Stephen G. 19a. Informant's Name/Relationship (T)		19b Mailing Addr	Ber ess (Street and Number or I	tha Wallac	Ce.	Zin Cordo)
Dartillors, Wally permit. Pages 1 and 2 shou Department of Health and M Important: If item 27 is man any injury or other treumsti once.		Caremlia A. Hicle 20a. Method of Disposition MSBurial 2 Cremation 3 F '4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens Lavry B. Rec	and Address of Facility	13/04 Sha	Location - City or	oMd		
Physician /Medical Examiner as the burial-transit	licai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cations that caused the death. Do	PL // Ce of): TC N 5 1 Ce of):	12/14/11/16	ac or respiratory arrest,	Md. 214	Approximate Interval Between Onset and Death
ath cer ttendir or use	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√2 No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown				23d. Date of del Month	ivery Day Year
w requires that the debeen signed by the a	ed by PI	Part II. Other significant conditions cor	tributing to death but not resulting	g in the underlying	g cause given in Part I.	23e. Did tobacco		the cause of death?
ician: The law r certificate has be rector, page 2 sh	e Completed	25. Was case referred to medical				24a. Was an autopsy performed?	prior to death?	itopsy findings available completion of cause of 2 No
To the Hospitel or Attending Physician: The law requires I within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be completely filled in by the funeral director.	To B	examiner?		Outpatient 3 D Time of Injury	Other	ath (Check only one) Home 5 Residence 28d. Describe how inju		cify)
tel or Atters after detail Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, s building, etc. (Specify)	farm, street, factor	ory, office	28f. Location (Street a City or Town, State	nd Number or Ru (e)	ral Route Number,
To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1' Certifying Phys Check only one)	icien: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death occurre and/or investigation	od at the time, date and plac on, in my opinion, death occ	e, and due to the cause(surred at the time, date an	s) and manner as nd place, and due	stated. to the cause(s)
To t To t	Σ	29b. Signature and title of certifier	Steinfell 1	10	9c. License number	29d. Di	ate signed (Month	o, Day, Year)
	1	20 Name and address of person who co	npleted cause of death (Item 23a)	(Type, Print)	17051. 6131 3H.	My Side	2076	e.j.
Sta Registr		31. Date filed (Month, Day, Year) JAN 1 2 20	32. Re listrar's Signature	R. Soul	الأ			

		•	For State Registrar	State of Ma	ryland /		rtment tificate			Mental H	ygier Reg. I	U	04	01617
ı	Physici	an	1. Decedent's Name (First, Middle, Las Helen Man		leberdi	ing				2. Date of I Month Januar	Death		Year	3. Time of Death 12:08 a. M
)	/Medic Examin	_	4a. Facility Name (If not institution, give	street and number)			4b. City, 1 Glen		Location of De			4c. County of	of Death	
	Funeral Director		Social Security Number 6. S		(In yrs. last b	irthday) Yrs.	If Under Months	1 Year Days	If Under 24 H Hours M	in. 8. Date of E (Month, I OCTODE	Birth Day, Yer ET I	ar) ,1915	9. Birthp	plece (State or Foreign http) y Land
	death with the Maryland ms 23a or 28a-f ahow	ctor	Usuel Residence of Decedent 10a. State 10b. County Maryland Anne Ar	rundel	10c. City, To									0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the	al Dire	10e. Street and Number 394 Washington Av	e.			10f. Zip	Code 1060				Citizen of W ited S		•
350	J within 72 hours after death with the Marylan jiene. I than "natural", or Items 23a or 28a-1 ahow Ite Medical Exduiner must be notified at	by Funeral Directo	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forcas? 1 Tyes 24 No If Yes, Give Year or Dates:	ver in U.S.		Vas Deced Yes, spec ☐ Yes 2	**	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or I erto Rican, etc.)	No-	14. Race Black Specify:	, White,	
1215-0036	filed within 72 hou Hygiene. ther than "natura int, the Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		-)	(Give I	ent's Usua kind of wor DD NOT us naker	l Occupa k done d e retired)	tion uring most of v	working		. Kind of Bus		dustry
yiand 2	be filed ital Hyg id othe event,	Be	17. Father's Name (First, Middle, Last) John Slawski							Name (First, Midd)	
Maryi	and 2 should ealth and Men n 27 is marke her traumatic	ပ	19a. Informant's Name/Relationship (19auline Shaney	Type, Print) (sister)					nd Number or	Rural Route Num	ber, Cit	y or Town, S		
saltimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 is marke any injury or other traumatic once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State		ery, crem	natory or of	her place	n Cmtr.	Jan 6	1	Cheste		own, State Maryland
Rait	permit. Departm Importa any inju		21. Signature of Funeval Euroice Licen	,	0982				s of Facility A	Adams Fur Annapol:	nera is,	1 & Me MD. 21	emori 1401	ial Care
8/60,	ate be executed Medical Examiner Inspired and Inspired	edical Examiner	23a. Part T. Enter the disease, or companies, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Met	consequence	e of):				ance or respiratory				Approximate Interval Between Object and Death Connection Control Contr
O. Box 6	death certif e attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at the good Unknown	Petal deal		Ectopic pre					23d. Date Mont		ery Day Year
'n	law requires that the de as been signed by the a 2 should be detached t	by	Part II. Other significant conditions of	ontributing to death bu	t not resulting	in the ur	nderlying ca	use give	n in Part I.		d tobacc	-		ne cause of death?
I Kecords,	The ate h page	Completed								24a. We	topsy rformed	? pr	or to cor	psy findings available mpletion of cause of
Viital	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?	Hamitali				0		Death (Check only	y one)			4 1 1
ō	Ing Phys	tlon: To	1 Yes 2 Here 27. Mann of Death 1 In latural 5 Pending 2 Accident investigation	Hospital: 1 Inpatier 28a. Date of Injury (Month, Day)	/ 28b	outpation Time of Injury		Bc. Injury Work	4 Nursing	g Home 5 ☐ Re 28d. Describ				y) Assisted Liv
Division	ai or Attending s after death. Il Director: After ed in by the fune	Certification:	3 Suicide 6 Could not be determined		ry - At home, . (Specify)	farm, stre	et, factory	, office		28f. Location City or 1	(Street own, St	and Number ate)	r or Rura	il Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical (29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of niner: On the basis of and manner stat	examination a	ge, death and/or inv	occurred a vestigation,	at the tim in my op	e, date and pla inion, death o	ace, and due to the courred at the tim	e cause	a(s) and man and place, ar	ner as st nd due to	tated. o the cause(s)
,	To t To t	Σ	29b. Signature and title of certifier	plate	b		290	License	0094		29d.	Date signed	(Month,	Day, Year)
			30. Name d address of person who	bulymy	ath (Item 23a	(Туре, <i>И</i>	Print)	Per	rk D	hive C	de	BU	rnie	44, 2106,
	Sta Regist		31. Date filed (Month, Day, Year) JAN 0 7	32. Redistra	r's Signature	* 4	Social			/			_	, , ,

			for State Registrar	State of Ma	ryland	-			ealth a Death	and M		giene Reg. No.	/ 11111	+ (01618
			Decedent's Name (First, Middle, Las	it)							2. Date of Dea	ath Day	Year		. Time of Death
	Physicia /Medic		ANDREW HOWAR	O NORTE	OP-10						JANUA		33 200		2:30 PM
	Examin		4a. Facility Name (If not institution, give	street and number)		26-	4b. City,	Town, or	Location o	of Death			County of De		0
			BROQUE GROVE RE			ENTER	S大!	1 700	If Under:		8 Date of Birth		10074		
	Funeral Director		5. Social Security Number 6. Security Number 1	9X /.Age D3M 2□F	88	Yrs.	Months	Days	Hours	Min.	8. Date of Birtl (Month, Day April 7	, Year) 1 Q 1	15 Vi	ountry)	(State or Foreign
			Usual Residence of Decedent				1			<u></u>	TPLIE 7	, 1).			
	how I		10a. State 10b. County		10c. City,	, Town or Loc	ation								Inside City Limits 1 ☐ Yes 2 ☑ No
	ith the Marylan or 28a-f ehow	Directo	Maryland Charle	es	La	Plata							/ 14 11 - / 07		
	with the	Dire	10e. Street and Number				10f. Zip					10g. Citi	zen of Whaf C	ountry r	
	72 hours after death with the Maryland 'reatural', or Iteme 23a or 28a-f ehow oldal Estaminar must be maillied at	Funeral	11573 Rest Drive	12, Was Decedent E	ver in U.S	S. 13. V	Vas Dece	2064 dent of Hi		gin? (Spe	cify Yes or No- Rican, etc.)	.	USA 14. Race - Arr	erican li	ndian,
	r ken	Fun	1 Never Married 2 Married	Armed Forces? 1 ⊠ Yes 2 □ N		1				i, Puèrto f	Rican, etc.)	1	Black, Wh		
3	72 hours after natural', or Ita	by	3 ⅓Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1943	-45 ¹	☐ Yes	21XI NO	Specify:				Specify: W	nite	<u> </u>
2	72 hours after dea "natural", or Iteme	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)		16a. Deced (Give	kind of wo	rk done d	furing most	t of workin	ng	16b. Ki	nd of Busines	s/Industr	ry
7	를 로	mp	Elementary/Secondary (0-12)	College (1-4or 5-	+)		oo not ii chmai)			То	1ephon	o Co	mnony
7	illed with Hygiene other the	e Co	17. Father's Name (First, Middle, Last)			SWIL	Ciilla	.1	18. Mothe	er's Name	(First, Middle,			e cc	эшрану
	0 a 2 2 €	To Be	Howard B. Nor	ford				İ	R	oberi	ta King				
ary	s 1 and 2 should of Health and Mer item 27 is marke other traumatic	-	19a. Informant's Name/Relationship (7			19b. Mailin	g Address	(Street a			Route Numbe		r Town, State,	Zip Coc	de)
Σ	and 2		Craig D. Norford	/ Son					rive,		lata,				
5	of He of He fitem		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Pla	ace of Dispos metery, crem	sition (Nar atory or o	ne of ther place	θ) .	o Janua	ate	20c. Lo	cation - City o	r Town,	State
Ĕ	G and and D		`4 □Donation 5 □ Other (Specify		Fort	Linco			ry	20	04			1, M	aryland
Баптато	permit. Pages 1 Department of H Important: If ite any injury or ott		21. Signature of Funeral Service Licen	See O		Fr:	Name an	d Addres	s of Facilit	ins F	uneral	Hom	e Inc.		00001
	403 e d		23a. Part1. Enter the disease, or comp	plications that caused	the death								r Sprii	Apr	MD 20901 proximate
	4		shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	θ.				9, 020		, , , , , , , , , , , , , , , , , , , ,			Inte	erval Between set and Death
	Physician /Medical		disease or condition resulting in death)	a. ACUTE Due to (or as a			31 DC) RE						D	AYS
	Examiner			b. D& HYD										DA	uis
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying								* * .				
	ocuted and transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Dys PH	ALTI	~								W	2845
/60,	ate be executed hysician and the burial-transit	E	resulting in death, Last	d. CEPER	Seconseque	ence or):	اسارا	a	DIS	EAS	らご			4	EAKS
20	physic	edical		d. Cert		J + 3 - 3 - 5 - 5								(
D X O	death certificate e attending phys id for use as the	J/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								2	23d. Date of de	elivery	
ă	death a atter	Physician/M	in the past 12 months?	1☐Live birth 4☐Pregnant at			Ectopic pr Other (sp					İ	Month	Day	Year
j.		hys	9 Unknown	9∐ Unknown											
Š	requires that the de een signed by the a hould be detached f	ру Р	Part II. Other significant conditions of	ontributing to death bu	ut not resu	lting in the un	derlying c	ause give	en in Part I.				2		ause of death?
000	v requir been si should					· · · · · · · · · · · · · · · · · · ·					1 U Y	es 2	No 3□F	robably	4 Unknown
ab .	aw 2 s b	Completed									24a. Was a autop	sy	24b. Were a prior to death?	comple	findings available tion of cause of
E E	Ti ale	Con									perfor 1 ☐ Yes	2. No	1 Ye		No
1 2	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		-5/0		Othe			(Check only of		TO:: 42		
ō	Phys r this ral di	: To	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatre	v	R/Outpatient 28b. Time of		28c. Injury Work	4 DU NU		ne 5 Resid			ecify)	
o	Attending ir death. ector: After by the fune	atlon:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	(Year)	Injury	м		(? Yes 2 ☐ I	No					
UNISION	Attendii rr death. ector: A by the fu	Ifice	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju-	ry - At hor	me, farm, stre	et, factor	y, office		2	28f. Location (S City or Tow		d Number or F	Rural Ro	ute Number,
5	spital or Attending Physician: ours after death. neral Director: After this certific filled in by the funeral director,	Certifica		Donaing, oto	(5500)	,							<u> </u>		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medicel Exan	ysician: To the best on niner: On the basis of	examinati										
	To the Hosl within 24 ho To the Fun completely f	Med	29b. Signature and title of certifier	and manner sta	ted.		290	c. License	number			29d Dat	e signed (Mor	th Day	Year)
	Z W Z		253. Signature and title of defined	STAFF PH	LKIC	IAN				6			-	-	
1	otl		30. Name and address of person who	completed cause of de	eath (Item	23a) (Type I	Print)	- 1	- 1	^		, , , , , _			70860
Ì			TRACE BROOKE H	JEFNAN, W	(·D.	18100	SLA	nog S	citoc	iko!	to San	oy S	SPRIN	4/	3,2004 20860 1APYLAND
	Sta	ite	31. Date filed (Month, Day, Year)	32. Hagistra	ar's Signati	ure 4	1.	a. V	/						
	Registr	ar	JAN 0 6 20	104 Sens	red -	N	jujo	uns							

			1 - For State Registrar	State of Marylar		artment of rtificate of			ene . No. 200	4 01619
0.	Physic /Medi	cal	Decedent's Name (First, Middle, Last Susan J. Noon Aa. Fecility Name (If not institution, give	, 		th Ch Tau		2. Date of Death Month January		2:12 P M
	Examir	ner	Washington Advent 5. Social Security Number 6. Se.	tist Hospital	(act histhday)		or Location of Death		4c. County of D	omery
	Funeral Director			TM 20XE	7.5 Yrs.	Months Days		8. Date of Birth (Month, Day, Y	1928 1	Birthplace (State or Foreign Country) Pennsylvania
036	72 hours after death with the Maryland instural, or items 23s or 28s-f show dical Examinational be notified at	by Funeral Director	10a. State		1	11e 10f. Zip Code 20	0783 Hispanic Origin? (S pan, Mexican, Puert Specity:		Black, W	merican Indian,
Maryland 21215-0036	within ene. than	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation le <i>completed)</i> College (1-4or 5+)	(Give	OO NOT use retire	during most of wor	king 16	b. Kind of Busine	
yland 2	be filed tal Hyg d other	To Be Co	17. Father's Name (First, Middle, Last) Lawrence Kratz		Arti	ST		ne (First, Middle, Ma Haughton	Art iden Sumame)	
re,	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic once.		19a. Informant's Name/Relationship (Ty Leslie Pickett/Da 20a. Method of Disposition ¹☼ Burial 2 □ Cremation 3 □ R ¹⁴ □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensi	aughter Removal from State	652 Place of Disposementery, cremoverside	Chapelvi sition (Name of patory or other pla Cemeter	ew Dr, Od	lenton, MD Date 2004 9, 2004 les-Rinald	21113 c. Location - City	or Town, State
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	ications that caused the deat ne cause on each line. Due to (or as a consequence)						Approximate Interval Between Onset and Death
. 68760,	death certificate be executed e attending physician and ad for use as the burial-transit	Aedical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq Due to (or as a conseq		0				
P.O. Box	that the death certific ed by the attending pl detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3 □	Ectopic pregnanc Other (specify)	у		23d. Date of o	lelivery Day Year
	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions con	stributing to death but not res	ulting in the un	derlying cause giv	ven in Part I.	23e. Did tobac	,	to the cause of death? Probably 4 Unknown
al Rec	The ate h page	Completed						24a. Was an autopsy performed 1 Yes 2	prior to death?	autopsy findings available o completion of cause of as 2 \(\sum \) No
Division of Vital Records,	S S D	tlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Input (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injur Wor	er: 4 ☐ Nursing Ho	h (Check only one) me 5 Residence 28d. Describe how in		pecify)
Divisi	i Fig it	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	<i>')</i>	et, factory, office		28f. Location (Stree City or Town, Si	ate)	
	To the Hospital within 24 hours a To the Funeral to completely filled	Medical	29a. Certifier (Check only one) 2 Medical Examin 29b. Signature and title of certifier	sician: To the best of my knoner: On the basis of examinal and manner stated.	wledge, death tion and/or inve	occurred at the tir estigation, in my o	ne, date and place, pinion, death occur	and due to the cause red at the time, date	e(s) and manner a and place, and do	as stated. ue to the cause(s)
	6		30. Name and address of person who con	MD	1 23a) (Type P	by Control of the con	887 <i>S</i>	290.	Date signed (Mor	5,2004
	Sta Registr		MEBARAL KARY 31. Date filed (Month, Day, Year) 1AN 0 7 200	M, T610 CHR 32. Registrar's Signal	POLL ture &	Sports	E, TAK	common Pr	HR.K.,	15 stated. 10 to the cause(s) 11th, Day, Year) 15, 2004 11D20912

		For State	State of Maryland / Department of Maryland / D		Mental Hygi	ene 2001. 01626
Physi /Mer	ician dical	Registrar Decedent's Name (First, Middle, Last Evelyn Johnson		Timodio of Dodin	2. Date of Death Month	Day 2004 5:00 A M
Exam		4a. Facility Name (If not institution, give 7601 Seans Terra		4b. City, Town, or Location of Death	1	4c. County of Ceath Prince George's
Funera Directo		5. Social Security Number 6. Se 138-44-8597		If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) July 31,	9. Birthplace (State or Foreign Country)
Maryland a-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince	George's Lanham			10d. Inside City Limits 1 □ Yes 2 ☑ No
h with th	ai Director	10e. Street and Number 7601 Seans Terra	ce	10f. Zip Code 20706	100	g. Citizen of Whal Country? United States
1215-0036 within 72 hours after death with the Maryland ene. then "natural", or Items 23a or 28a-f show he Madical Evaluation to colification.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 XNo	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 【X No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-1 ehow eny injury or other traumatic event, the Medical Examate must be rediffed at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	e completed) (Give	dent's Usual Occupation kind of work done during most of wor DO NOT use retired) tered se / Administr	king	Bb. Kind of Business/Industry Medical
yland yland yland Mental Hyg	To Be C	17. Father's Name (First, Middle, Last)		18. Mother's Nam Eliza	ne (First, Middle, Ma Johnson	aiden Sumame)
Mar and 2 sho alth and 27 Is m	1	19a. Informant's Name/Relationship (Ty Eddie M. Nelson	(Husband) 19b. Mailir (Husband) 760	ng Address <i>(Street and Number</i> or <i>Ru</i> 01 Seans Terrace		
Baltimore, Dermit. Pages 1 ar Department of Heal mportant: If Item any injury or other		20a. Method of Disposition 1 □ Burial 2 [X]Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		natory or other place) Janu	Date ary 4,	Dc. Location - City or Town, State Beltsville, Md.
Balti permit. Departi Imports eny inju	dia	21. Signature of Funeral Service Licens	ode Moisa	Rapp Funeral AND 933 Gist Ave., S	Cremation ilver Spri	n Services ing, Md. 20910
, Physiciai /Medica		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Endometral Car	er the mode of dying, such as cardiac	or respiratory arrest	t, Approximate Interval Between Onset and Death
Examine	r)	ruction		
60, be executed sician and burial-transit	cai Examiner	Sequentially list conditions, if any, leading to manufacte cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Renal Failure Due to (or as a consequence of):			
.O. Box 687 the death certificate y the attending physiched for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2♥No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
COTGS, P w requires that been signed b should be deta	þ	Part II. Other significant conditions con	stributing to death but not resulting in the ur	nderlying cause given in Part I.		cco use contribute to the cause of death? 2 No 3 Probably 4 □Unknown
	Completed				24a. Was an autopsy performer	
on of ling Phys I. After this uneral di	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 Xo 27. Manner of Death 1 Xatural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 ER/Outpatien 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	t 3 DOA Other: 4 Nursing He	th (Check only one) ome 5 A Residence 28d. Describe how	te 6 Other (Specify) injury occurred
DIVISION al or Attending s after death. Il Director: Afte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
DIVI Ne Hospital or Al n 24 hours after of he Funeral Direct pletely filled in by	edical (29a. Certifier (Check only one) 1 X Certifying Physical Examination (Check only one)	iclian: To the best of my knowledge, death ler: On the basis of examination and/or inv and manner stated.	occurred at the time, date and place, restigation, in my opinion, death occur	and due to the caus red at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
To the To the compl	W	29b. Signature and title of certifier	0200	29c. License number (1) 39 14 3	29d.	Date signed (Month, Day, Year)
Q		30. Name and address of person who charles R. Boice	pleted cause of death (Item 23a) (Type, I , M.D.; 10301 Georg	Print) ia Ave, # 205, Si	lver Spri	ng, Md. 20902
S Regis	tate trar	31. Date filed (Month, Day, Year) 1AN 0 6 2004	32 Registrar's Signature	Sports		

			1 - For State Registrar	State of Maryla		artment rtificate			d Menta	al Hygiei	$ \angle$ \cup	0	0162
	Physic	an	Decedent's Name (First, Middle, Last)							te of Death onth	Day Y	/ear	3. Time of Death
	/Medi	cal	Helen Margaret 4a. Facility Name (If not institution, give	0ak		45 O.5. 7	Faura	l anning of D		uary 1			12:20 P ^M
	Examir	ier	Mairner of Greate				ure1	Location of D	eath		4c. County of		1 -
	Funeral	-	5. Social Security Number 6. Sex	7. Age (In yrs	s. last birthday)	If Under	1 Year	If Under 24	Hrs. 8. Dat	te of Birth onth, Day, Ye	Prince		ce (State or Foreign
	Director		109-14-3209	M 25xF 82	Yrs.	Months	Days	Hours N	Jar	n 16,	921	Iowa	y)
	and		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation						100	d. Inside City Limits
	Maryl f sho	ō	Maryland Prince G		aure1								1x Yes 2 No
	r 28a	Director	10e. Street and Number	eorge S L	aurer	10f. Zip	Code			10g.	Citizen of Wh	at Country	y?
	th wit	aiD	7700 Cherry Lane			20	707			υ.	S. A.	•	
	tams	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decede	ent of His	panic Origin' , Mexican, P	? (Specify Ye	es or No-	14. Race - Black	American White, etc	
36	, or t	by F	1 Never Married 2 Married 3 Widowed 4 X Divorced	1 ∐ Yes 2 Ž∭ No lf Yes, Give Year or Dates:		1 ☐ Yes 2		Specify:		ŕ	Specify:	Whi	
9	be filed within 72 hours after death with the Maryland nat Hygiene. ad other than "natural", or Itams 23a or 28a-f show event, I'm Medicul Exarting must be notified at		15. Decedent's Edu	cation	16a. Dece	dent's Usual	l Occupat	ion		16b.	Kind of Busin		
215	within 7: lene. then "n	pie	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work DO NOT use	k done du e retired)	ring most of	working				· · · ·
7	filed wil Hygiene other the	Completed	12	6	T	'eache	r				Educa	ation	
nd	be filed ntal Hygid of other event, I	Be	17. Father's Name (First, Middle, Last)	_					,	Middle, Maid	en Sumame)		
7	should be ind Mental marked o	2	William Wilber Oa 19a. Informant's Name/Relationship (Ty)		10h M-35	an Andreas		Mini P		11 1 0"		. 7 0	
Maryland 21215-0036	d d 2		David Kriebs/Nephe	•					Bowi.	Number, City	20715		ode)
ē,	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr. 90ce.	1 10	20a. Method of Disposition		Place of Dispo	sition (Name	e of		Date		Location - Ci		n, State
Baltimore,	Page nent o nnt: If nry or		1 ☐ Burial 2 X Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)		intt Cre	-		1	/14/20	04 Wa	ldorf	Mary	11 and
alt	permit. Departm Imports any inju	1	21. Signature of Funeral Service License					of Facility	Robert	E. E.	ans Fu	inera	1 Home,
	99 = 9		KILK		16	000 A	nnap	olis R	load, E	Bowie,	Mary1a	and	20715
No. Sec.	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	Rena)	er the mode	, -		diac or respir	atory arrest,		In	pproximate iterval Between inset and Death
8760,	death certificate be executed be extending physician and dror use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):	d (ar	cinon	na			1	month
O. Box 6	death certif e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	aldeath 3⊑	Ectopic pre				7.90	23d. Date o Month	. ,	y Year
ords, P.O.	The law requires that the deate has been signed by the a page 2 should be detached to	ρ	Part II. Other significant conditions con	tributing to death but not re	sulting in the ur	nderlying car	use given	in Part I.	236		20		cause of death?
al Records,	Physician: The law rathis certificate has be this certificate has be al director, page 2 sh	Completed	25. Was case referred to medical						1 🗆	a. Was an autopsy performed?	prio	r to compl th?	findings available letion of cause of
5	Physician: r this certifica ral director, I	To Be	examiner?	ospital: 1] ER/Outpatien	3 DOA	Out		Death Check	Residence	6 Other /	Cassiful	
Division of Vital		ation: T	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		c. Injury a Work?			scribe how inj		<i>эрвспу)</i>	
Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stre fy)	et, factory,	office			ation (Street a or Town, Sta		or Rural Re	oute Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	ledical	one)	ician: To the best of my knier: On the basis of examinand manner stated.	owledge, death ation and/or inv	estigation, in	t the time n my opir	, date and pla non, death o	ace, and due courred at the	to the cause(time, date a	s) and manne nd place, and	er as state due to the	d. e cause(s)
i	with To Corr	Σ	29b. Signature and title of certifier	1 lo M	0		D 5	448	8		ate signed (A	-	*
			30. Name an laddress of person who con Bennett 50	, MD, 8	317 (Cher	ry	Lane	, Lau	ivel,	MD	20	707
	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 4 20	32. Registrar's Sign	ature	Good	9						

	1	For State Registrar	ate of Mai	ryland / Depa <i>Cei</i>	artment of H rtificate of L			giene 1eg. No. 200	01622
-		Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day Yeer	3. Time of Death
Physician		Shirley I.	0'Brya	nt			January		3:14 a. M
/Medica Examine	-	a. Facility Name (If not institution, give stree	and number)		4b. City, Town, or	Location of Death		4c. County of Dee	th
		7877 Bellehaven Ave			Pasadena		Y	Anne Arı	
Funeral Director	1	5. Social Security Number 6. Sex 1 M	_	(In yrs. last birthday) 95 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day Novembe	^{9. Bir} er 24,1908 Ke	thplace (State or Foreign ountry) Entucky
Q	—	Usual Residence of Decedent		10- Cit. T					10d. Inside City Limits
arylar show		10a. State 10b. County		10c. City, Town or Lo					1 Tyes 2 No
8a-f	2	Maryland Anne Arunde	∃T	Pasadena				10a. Citizen of What C	
Mith th	5	10e. Street and Number			10f. Zip Code				•
eath se 23a		7877 Bellehaven Ave	Vas Decedent Ev	ver in U.S. 13.1	21122 Was Decedent of Hi	ispanic Origin? (Sp		Jnited Stat	
Ite; Mal ylailu KIKIS-0000 8 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or liems 23a or 28a-f show other traumatic event, ite Madical Examiner must be notified at	Dy run	1 Never Married 2 Married 1	med Forces? ☐ Yes 2X No Yes, Give 'ear or Dates:	,	f Yes, specify Cuba 1 ☐ Yes 2€ No	n, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi	nite
thour street		15. Decedent's Educatio	n	16a. Dece	dent's Usual Occupa	ation		16b, Kind of Business	/Industry
nin 7	Completed	(Specify only highest grade cor	npleted) College (1-4or 5+	life.	kind of work done of DO NOT use retired	during most of work ()	ing		
d with giene	e	8		Home	maker			Own Home	9
d be file intal Hy intal Hy control of the control	De	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
ould I	0	John Van Hoose		401 14 111		Sarah B		- O'the - Town Class	Tin Code)
VICE SH H and VICE IT IT IT IT IT IT IT IT IT IT IT IT IT	1	19a. Informant's Name/Relationship (Type, I						r, City or Town, State,	
Tand 2 Health Health other tra	d.	Esta Ginneman (daug 20a. Method of Disposition	ghter)	20b. Place of Dispo	sition (Name of		Pasadena Date	MD. 2112 20c. Location - City or	
permit. Pages 'Department of himportant: If Ite any injury or of once.		1 X Burial 2 ☐ Cremation 3 ☐ Remo	val from State		natory or other place Cemetery		9, 2004	l Champai	.gn, Ohio
DELLITION Permit. Pages Department of mportant: If it my injury or or	-	4 □ Donation 5 □ Other (Specify) 21. Signature of Fine at Gervice Licensee						eral & Memo	
Dealth permit. Departr Imports any inju		1) Rasham		1.00				s, Marylan	
4-8-7-1		23a. Pert1. Enter the disease, or complication shock, or heart failure. List only one call	ns that caused t	he death. Do not ent					Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	Conge	stive 1	Leart	taile	ire		months
/Medical Examiner		resulting in death)	Due to (or s a	consequence of):					
	١	Sequentially list conditions, b.	Due to or as a	consequence of):					
uted Insit	Examine	cause. Enter Underlying Cause (Disease or injury							
be executed ician and burial-transit	EX	that initiated events c resulting in death) Last	Due to (or as a	consequence of):					
of our	alcai	d						_	
certificate oding phys	Je d	IS SERVICE.		****					
BOX 06/00, eath certificate be executed attending physician and for use as the burial-transit	nysician/me	23b. Was decedent pregnant	f yes, outcome o	Fetel death 3	Ectopic pregnancy			23d. Date of de Month	livery Dav Year
he death the the attenth ched for u	200		I□Pregnant at ti D□Unknown	ime of death 5	Other (specify)				5.,
d by i	J.	Part L Other significant conditions contribu	iting to death but	t not resulting in the u	nderiving cause give	en in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
wrequires that the de been signed by the should be detached	D O	Dementia	ing to coult but	that resulting in the a	indonying outcoo give		1 🗆 Y	es 2 □ No 3 □ P	robably 4 Hinknown
w requires been sign should be	ompleted						24a. Was a	an 24b. Were a	utopsy findings available
VICAL MEC	E E						autop	med? prior to death?	completion of cause of
	၁ .	25. Was case referred to medical				26. Place of Deat			s 2 No
OT VITA Physiclan: rithis certific ral director,	0	examiner? 1 Yes 2 No Hosp	tal: 1 ☐ Inpatien	nt 2 ☐ ER/Outpatier	nt 3 DOA Othe	00	-	ence 6 Other (Spe	ecify)
On Or VITal ding Physiclan: th. After this certifice funeral director, s	<u> </u>	-/-	Ba. Date of Injury (Month, Day	Year) 28b. Time o	f 28c. Injun Worl	y at k?	28d. Describe h	ow injury occurred	
endin sath. or: Aff	atic	2 Accident investigation			M 1 🗆	Yes 2 □ No			
INISION I or Attending after death. Director; Afte	Certification:	3 Suicide 6 Could not be determined 2	Se. Place of Injur building, etc.	ry · At home, farm, st. (Specify)	reet, factory, office		28f. Location (S City or Tow	itreet and Number or R n, State)	lural Route Number,
		29a. Certifier 1 Certifying Physicia 2 Medical Examiner:	On the basis of e	examination and/or in					
thin 2 the omplet	Medical	29b. Stanature and title of certifier	and manner state	. Dec.	29c. Licens	e number		29d. Date signed (Mon	th, Day, Year)
F 3 F 3		July		MU		507	25	1-5-	2004
		30. Name and address of person who compl	eted cause of de	eath (Item 23a) (Type	Print) Perar	stur	1 M.	Mersul	le mis
Stat Registra	-01	31. Date filed (Month, Day, Year) JAN 0 7 200		r's Signature	Soule a	0			21108

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

					Olale 0	i iviai yi				Death	I WEILLAI FI	Reg. No.	2004	0 1	623
	,		1. Decedent's Name (First, Mic	ldle, Last)							2. Dete of D	eeth	Vees	3. Time o	of Death
	Physicia /Medic		L	AWREN	ICE JOS	SEPH (TT				Januar	y 1,	2004	11:00	0 PM
	Examin	_	4e Fecility Neme (If not institut	ion, give s	treet end nur	nber)				4b. City, Town,	or Location of Dee	th 4c. Co	ounty of Deeth		
	<i>3.</i>		15851 Smith R	_						Thur			ederic		
ı	Funeral Director		5. Social Security Number 219–12–2292	6. Sex 1 ☑	M 2□ F	7. Age (In)	rrs. lest birthd 81 Yrs	Months	er 1 Year Days		lrs. 8. Date of B lin. (Month, L March	19, 19	9. Birth Cou 922 Ma	place (State ntry) rylanc	or Foreign d
	D .		Usuet Residence of Decedent 10a. State 10b. Coun	he		100	City, Town or	Location						104 1-14-6	24 6 114
	the Maryla 28e-f ehor	ctor	Maryland Fred			100.	Thurn							10d. Inside C	s 2 No
	計 94.28	Oire	10e. Street end Number					10f. Z	ip Code			10g. Citizer	of Whet Cou	ntry?	
	ath w	la l	15851 Smith Ro						1788				J.S.A.		
50	72 hours after death with the Maryland natural', or items 23a or 28s-f show ileal Examinar must be notified at	y Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Ma	arried	2. Was Dece Armed Fo 1 XYes If Yes, Giv	rces? 2 ∐ No 'e				Hispanic Origin? pan, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)		Race - Americ Black, White, ecity:		
00	ural',	d by	3 Widowed 4 Divorce		Year or Da	ates: WV	VII						Wni		
21215-0020	within 72 ane. than "nat	Be Completed	15. Decede (Specify only high Elementery/Secondary (0-12)	est grade	completed) College (1	-4or 5+)	(G life	cedent's Usive kind of w b. DO NOT	ork done use retire	pation during most of i ad)	working		of Business/In .umbing		
0	al Hygid other	ပ္	17. Fether's Neme (First, Middle	a, Last)			1 1	Tumbe.	L	18. Mother's N	lame (First, Middle				
Maryland	id be ental ked o	TO B	John Baptist O	tt, S	Sr.					Ida Ama	ında Mill	er	,		
ary	should by nd Mente marked umatic e	F	19a. Informent's Name/Relation				19b. Ma	aiting Addres	s (Stree	t and Number or	Rural Route Numi	per, City or To	own, State, Zig	Code)	
×	is 1 and 2 should be filed. If Health and Mental Hygitem 27 is marked other other treumatic event,	ĺ	Lee Ott (Son)								Box 803				21727
Baltimore,	Pages 1 and ient of Health nt: if item 27 ry or other t		20a. Method of Disposition 1		moval from		b. Place of Dis cemetery, c ue Rid				Date 1/5/04		on - City or To		1
Balti	permit. Page Department of Important: if any Injury or once.		21. Signature of Funeral Service	icense	Que	-	R	OBERT	nd Addr	DAILEY &	SON, FUN	ERAL H	OMES,	-	
		\dashv	23a. Parl1. Enter the diseese, shock, or heart faiture. Li	or complie	ations that co	aused the d							21700	Approximat	te
)	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	st only one	R	smille.	istor	y f	ail	lui			1	Interval Bet Onset and	Death
	ted nsit	nlner		b .	ad	van	ced C	tuon	ic C	Ilistu	ective 1	ling	Discon	144	lais
,09	icate be executed physician and s the burial-transit	Medical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events) 6.		Due to	o (or as à cons	sequence of)	:			0		0	
x 68760,	ding phys	Medic	resulting in deeth) Lest	ال ه		Due to	(or as a cons	equence of)	:						
Box	atten for u	clan													
P.O.	y the ached	ysi	Part II. Other significant condit	ions conti	ributing to de	eth but not i	resulting in the	underlying	cause gir	ven in Part I.			contribute to		
	es that the death cer igned by the attendir be detached for use	by Physician/	Coronary	(U	Men	× 19	rela	1			_ '20	Yes 2□ N	lo 3∐Prol	bably 4□	Unknown
Records,	requir been s should	Completed) ——)						an autopsy ormed?	ava	ere autopsy f ailable prior t mpletion of o death?	to
æ	The la	E									_ 10	Yes 20(N]Yes 2□	No
Vital	lan: rtifica ctor, p	Be	25. Was case referred to medic examiner?	al						26. Place of D	eath (Check only	one)			
of <	Physician: rthis certific ral director,	0	1 ☐ Yes 2 No	Но	spital: 1 ☐ Ir	patient 2	☐ ER/Outpat	ient 3□ D	OA Oth	ner: 4□ Nursing	Home 5 X Res	dence 6 🗆	Other (Specify	1)	
٥	fter th		27. Manner of Denth 1 Neturel 5 ☐ Pend	ing	28a. Date o (Month	f injury n, Dey Year,	28b. Time Injury		28c. Injui Wo		28d. Describe	how injury oc	curred		
sio	Attending or death. actor: After by the fune	cat	2 Accident inves 3 Suicide 6 Could	igetion I not be			1	М		Yes 2 □ No					
Division	tal or Attendi	Certif	4 Homicide deter	mined	28e. Place buildin	of Injury - Al g, etc. <i>(Spe</i>	t home, farm, ocify)	street, factor	y, office		28f. Location (City or To		umber or Rura	l Route Num	iber,
		edical Certification:	29a. Certifier (Check only one)	ng Physic I Examine	r: On the ba	sis of exami	nowledge, de nation and/or	ath occurred investigation	at the time, in my c	me, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and date and pla	manner as st ce, and due to	ated. the cause(s	;)
	To the To the company		29b. Signature and title of partition	er	(1 / 1 -	111	29	c. Licens	se number		29d. Date sig	gned (Month, I	Day, Year)	
	7		30. Name and address of person	211	pleted cause	of deeth (I	em 23a) (Typ	e, Print)	121	P	itsburg	Md	1101	2172	7
	State	е	31. Date filed (Month, Day, Yeer		32. Re	gistrer's Sig	nature	4		E WWW	IIIDUTO	IVO	1		- 1

			For State Registrar	State	of Marylan		artment of H		Mental Hygie	ene2004	01624		
			Decedent's Name (First, Middle,	Last)					2. Date of Death		3. Time of Death		
	Physici	an	Mary Jane Plum	ner					January	7, 2004 Year	6:55 AM [™]		
	/Medic		4a. Facility Name (If not institution, g		ımber)		4b. City, Town, or	r Location of Dea		4c. County of Dea			
	Examin	er	255 Lums Road		,		North	East		Cec	i 1		
	· Francisco			. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hi	s. 8. Date of Birth	O Die	thplace (State or Foreign		
	Funeral Director		215-32-4673	1□M 2፟∭ F	68	Yrs.	Months Days	Hours Mi	December	$\overset{\text{ear}}{26}$, 1935	Maryland		
Н			Usual Residence of Decedent										
	yland Yang		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits		
	Mar.	ē	Maryland Cec	i 1		North	East				1 ☐ Yes 2X No		
	28 a	Directo	10e. Street and Number				10f. Zip Code		100	g. Citizen of What Co	ountry?		
	3a o at		255 Lums Road				21	901		United St	ates		
	daadt	Funeral	11. Marital Status		edent Ever in U.	.S. 13.	Was Decedent of H	ispanic Origin?	Specify Yes or No- erto Rican, etc.)	14. Race - Ame			
(0	tar tar	[교	1 Never Married 2 Marrie	Armed F	2 No		ryes, speciny Cuba 1 □ Yes 24 No		eno Alcan, etc.)	Black, Whit			
ဗ္ဗ	urs a	6	3 ☐ Widowed 4 🎇 Divorced	If Yes, G Year or I	ive Dates:		TLIYES 2411NO	Specify:		Specify:	White		
21215-0036	72 hours after death with the Maryland Insture!; or Itame 23e or 28e-f ehow dicel Examiner must be notified at	Completed	15. Decedent's	Education	,	16a. Deced	ient's Usual Occup kind of work done	ation	norking 16	b. Kind of Business	/Industry		
Ξ	F - F - F	e e	(Specify only highest Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retired	d)	Simily				
2	E TE ON	ПО	12			C.	ashier			Retail			
ğ	e Hyger	Bec	17. Father's Name (First, Middle, La	ist)				18. Mother's N	ame (First, Middle, Ma	iden Sumame)			
Maryland	parmit. Pages 1 and 2 should be illad within 72 hours aftar death with tha Marylan Dapartment of Health and Manthi Hyglena. Dapartment of Health and Manthi Hyglena. Important: If Item 27 is marked other then "naturel; or Itame 23a or 28a-f show any injury or other treumette event, the Madical Examinat must be notified at angle. Date.	T0 B	Albert William P	lummer				Mary M	arshall Ba	rbre			
3	od od od od od od		19a. Informant's Name/Relationship	o (Type, Print)		19b. Mailir	ng Address (Street	and Number or I	Rural Route Number, (City or Town, State, .	Zip Code)		
Ž	27 is a		Benjamin R. McRo	berts/Co	d, Nort	h East, Ma	ryland 21	901					
ō,	Hear Hear other		20a. Method of Disposition			Date 20	c. Location - City or						
2	y or		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		Jan	uary 12, 004 B	el Air, M	arvland					
Baltimore,	artme ortan		21. Signature of Funeral Service Li		4	rouch Fune		arytand					
Ba	Dapa Dapa Impo any i		11114								ryland 21901		
		\vdash	23a. Part1. Enter the disease, or o	omolications that	caused the deat						Approximate		
			shock, or heart failure. List or	nly one cause on	each line.					Interval Between Onset and Death			
	nysician		Immediate Cause (Final disease or condition resulting in death)	_a. Me	TAS 7247		CARCIV	1cm	Briss		5		
	/Medical Examiner		resulting in dealtry	Due to	(or as a conseq	uence of):							
0	LAGIIIIICI		Sequentially list conditions,	b		0							
	D #	<u>ē</u>	if any, leading to immediate cause. Enter Underlying	Due to	(or as a conseq	uence of):							
	icata ba exacutad physician and s tha buriai-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c	·								
0	a existen a uriai-		lesulary ar dealify cust	Due to	o (or as a conseq	uence or):							
8760,	ata b hysic ha b	dicai		d									
9	laath cartifice attanding ph I for usa as ti	S S	IF FEMALE:										
Вох	The lew requiras that the death cartiflo ate hes been signed by the attending p page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant		utcome of pregna birth 2 Feta		Ectopic pregnancy	,		23d. Date of de Month	livery Day Year		
	daa be att	200	in the past 12 months? 1 ☐ Yes 2-2 No	4⊟Preg 9⊟Unk	nant at time of d	leath 5	Other (specify)			William	Day 1 out		
P.0	that tha da lad by the a datached	ğ	9 Unknown	3630111									
	sw requiras that s been signad t ? should ba data		Part II. Other significant condition	s contributing to	death but not res	ulting in the u	nderlying cause giv	en in Part I.			the cause of death?		
Ö	quire an sig	Pe							1 ☐ Yes	2 2√√16 3 □ P	robably 4 Unknown		
ပ္ပ	s bec	Completed by							24a. Was an	24b. Were a	utopsy findings available completion of cause of		
Re	ha le e he age	Ē							autopsy performe	ad? death?	No		
of Vital Records,	in: T ifficat or, pi	Ü	25. Was case referred to medical					26. Place of D	eath (Check only one)	·			
Š	sicia cert iract	00	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DOA Oth	OF CHARGO COLLABORATION OF THE COLUMN TWO COLUMN TO COLUMN TWO COL	Home 5 Fesiden		city)		
of	Phy rale rale	. To	27. Manger of Death	28a. Date (Mo	y at k?	28d. Describe how		5.177					
o	ding Afta fune	를	1 Natural 5 ☐ Pending 2 ☐ Accident investiga										
S	deat deat ctor: y tha	ica Ica	3 Suicide 6 Could no	ot be 28e. Plac			et and Number or R	ural Route Number,					
Division	Dir.	Certification;	4 Homicide determine	buil	ding, etc. (Specit	(y)			City or Town,	State)			
	To the Hoepital or Attending Physicien: Tha lev within 24 hours after death. To the Funeral Director: After this certificate hes complataly illiad in by the funeral director, page 2	Ö	29a. Certifier 1 Certifying	Physician: To the	ne best of my knr	owledge, deat	h occurred at the tir	ne, date and ola	ce, and due to the cau	se(s) and manner a	s stated.		
	Fur Fur staly	edicai	(Check only 2 Wedical E	xaminer: On the	basis of examina	ation and/or in	vestigation, in my o	pinion, death oc	curred at the time, dat	e and place, and due	to the cause(s)		
	ithin the orthe	Me	29b. Signature and title of pertifier	1			29c. Licens	e number	290	t. Date signed (Mont	h, Day, Year)		
	F ≯ F 8	11 1/1/1/11/11 101858mD 11									1/01/04		
			1000	1000		n 03c\ /T	Drint)	0 0	3 ""/	1///	/		
	1		30. Name and address of person w	no completed ca	use of death (Iter	n 23a) (Type,	Print)	C-1	J FIL	J	6 2102.		
			31 Date filed (Month Day Very)	~ U-R	Registrarie Sinn	204	2047h	STree	7 4/1	IUN, M	リーイノラベバ		
	Sta Regist	ate											
	negist	rai	IANAG	2004 K									

			1 - For State Registrar	State of Maryland		artment of H tificate of I			giene Reg. No. 2	04	01625
	Physicia	'n	1. Decedent's Name (First, Middle, Last					2. Date of De Month	Day	Year	3. Time of Death
4	/Medic		JOHN ARTHUR	PRITCHARD		4b. City, Town, or	Leasting of Dani	ANGE	4c. County	of Dooth	1450 M
	Examin	er	4e. Facility Name (If not institution, give 3819 Each 61.	street and number)		0	c Location of Dear	lΠ	1 54		6 2000 5
	Eugeral		5. Social Security Number 6. Se	x 7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Bir	th	9. Birthpl	ace (State or Foreign
	Funeral Director		533-36-2348	₹ ^{M 2□F} 64	Yrs.	Months Days	Hours Min	JUNE 19		TENN	ESSEE
	D >		Usuel Residence of Decedent 10a. State 10b. County	10c City	Town or Lo	cation				16	0d. Inside City Limits
	ahov	ō		GEORGE'S BOV							1 K Yes 2 □ No
	the A	rect	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Coun	try?
	3a or	0	3819 EARLY GLOW L	ANE		207	16		U.S.A.		
	death	ner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	. 13.	Was Decedent of H	lispanic Origin? (S	Specify Yes or No	- 14. Rac	e - Americ	
9	be filed within 72 hours after death with the Maryland mal Hygiene. ad other than "netural", or items 23a or 28a-f ahow avent, the Medical Examiner must be notified at	Completed by Funeral Director	1 Never Married 2 Married	1 X Yes 2 □ No		1 ☐ Yes 2 ☑ No	Specify:	,,		· WHI	
21215-0036	ural',	d b	3 ☐ Widowed 4 🏋 Divorced	Year or Dates: 1964-6	58	dent's Usual Occup	etion		16b. Kind of Bi		
7	in 72	olete	15. Decedent's Ed (Specify only highest grad	ie completed)	(Give	kind of work done	during most of wo	orking	U. S.		,
212	swithin piene. r than	omi	Elementary/Secondary (0-12)	College (1-4or 5+) 4	PHYS]	CAL SCIE	NTIST		GOVERN		
	e filed within al Hygiene. I other than '	Bec	17. Father's Name (First, Middle, Last)					me (First, Middle		10)	
<u>a</u>	should be ind Mental is marked o	10	JOHN RALPH PRITC	HARD				OUISE DU			
Maryland	and and is m	i s	19a. Informant's Name/Relationship (7			9TH ST.,			-		Code) 22203
	other tr		ROBERT T. PRITCH			Sition (Name of	NORIA 1	Date Date	20c. Location -		
Baltimore,	permit. Pages Department of Importent: If Ite any injury or of		1 X Burial 2 ☐ Cremation 3 ☐	Removal from State		natory`or other plac VETERANS		2/2004		•	MARYLAND
Iţi	artme orteni injury		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen			2. Name and Addre					
Ba	Depa Impo any id		Je P. Kini	Q.		5000 ANNA					20715
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death.	Do not ent	ter the mode of dyin	ng, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Arterosel	so Tic	. Hype	terrive	- Hent	Dis sen	معر	Onset and Death
	/Medical		resulting in death)	Due to (or as a conseque							
42	Examiner	_	Sequentially list conditions,	b. Due to for as a conseque	ance of						
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence or):						
	sician and burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or as a conseque	ence of):						
09289	death certificate be executed the attending physician and of for use as the burial-transit	calE		d							
.89	tificati ig phy as the	ba									
Вох	eath certifical attending phi for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal		☐Ectopic pregnancy	4			te of delive	ry Day Year
	it the dea by the ati tached fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de- 9☐Unknown	ath 5[Other (specify)			1410	*101	ou, rou
P.0	The law requires that the tie has been signed by the bage 2 should be detache		Part II. Other significant conditions of	ontributing to death but not resul	lting in the u	enderiving cause gry	en in Part I.	23e. Did	tobacco use cont	ribute to th	e causa of death?
ds,	uires tha signed Id be del	1 by	Takin, outsi significant south			g caase g.			Yes 2□No	3 Prob	
Record	w requ	Completed						24a. Was	an 24b.	Were auto	psy findings available
Re	The lav	dmo			,			auto perf	psy ormed?	prior to cor death?	npletion of cause of 2□ No
Vital		a)	25. Was case referred to medical				26. Place of De	1 ☐ Yes		1 🗆 Yes	2 140
<u> </u>	Physicien: r this certific ral director,	0	examiner? 1/2 Yes 2 No	Hospital: 1 Inpatient 2 E	ER/Outpatie	nt 3 DOA Oth	ner: 4 🗆 Nursing	Home 5 Tes	idence 6 □Oth	er (Specify	<i>(</i>)
n of	ding Ph h. After th funeral	J: L	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Injur Wor	rk?	28d. Describe	how injury occur	red	
siol	Attending ir death. ector: Aflei by the fune	catic	2 Accident investigation				Yes 2 □ No		(0)		
Division	l or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specity,	ne, farm, st	reet, factory, office			(Street and Numb wn, State)	er or Hura	I Houle Number,
	ospital hours a uneral E		29a. Certifier 1 ☐ Certifying Ph	ysician: To the best of my know	viedge deal	th occurred at the til	me date and place	ce, and due to the	cause(s) and ma	anner as st	ated.
	24 H	Medicai		niner: On the basis of examinati and manner stated.							
	within To the comple	Me	29b. Signature and title of certifier	16 2		29c. Licens	se number		29d. Date signe	d (Month,	Dey, Year)
			Larador	phosto,)	0	14	0055 9	27	JANUE	7 5	7004
			30. Name and address of person who	1 - 1	23a) (Type		11	. 0		y s	
			SALVADER SE (No. 1) Date filed (Month, Day, Year)	32. Restrar's Signat	3 seta	1 Sion	7	my.	Mary 1	MNd	
*	St Regist	ate rar	JAN 0 7	2004	B	Society.					

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For Stata Registrar	State of	Marylan	d / Depa <i>Cei</i>	artment of H tificate of L	ealth a Death	nd Mental I	Hygien		01626
			1. Decedent's Name (First, Middle, Last)					2. Date o Month		ay Year	3. Time of Death
	Physici: /Medic		Laura Belia Penna	a					Janu			9:00A M
	Examin		4a. Facility Name (If not institution, give	street and numi	ber)		4b. City, Town, or	Location of	f Death	4	c. County of Deat	th
			19706 Frog Eye Ro	oad			Knoxvi]				Washingt	
	Funeral		5. Social Security Number 6. Se	x 7]M 21⊠F	. Age (In yrs. I		If Under 1 Year Months Days	Hours	Min. (Month	. Day, Year	9. Birt Co	thplace (State or Foreign puntry)
	Director		460-48-8962	JIVI 2201	68	Yrs.			Oct 3	3, 193	35 E1P	aso, Texas
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City	r, Town or Lo	cation					10d. Inside City Limits
	Aaryl f sho	ō	MD Washing	gton	Kn	oxvill	.e					1 ☐ Yes 2 ☑ No
	the t	ect	10e. Street and Number	-			10f. Zip Code			10g. C	itizen of What Co	ountry?
	3a or	Funeral Director	19706 Frog Eye Ro	oad			21758				USA	
	Jeath ms 2; mus	era	11. Marital Status	12. Was Deced	lent Ever in U.	S. 13.)	Was Decedent of Hi	spanic Orig	nn? (Specify Yes o	r No-	14. Race - Ame	
(0	or Ital	표	1 ☐ Never Married 2 🗷 Married	Armed Ford	No No	i	f Yes, specify Cuba		, Puerto Hican, etc.)	Black, Whit Specify: Wh	
ତ୍ର	ral', c	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dat	tes:		1 ☐ Yes 2 🔯 No	Specify:			Specify: W1	
2-0	72 h	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)		(Give	dent's Usual Occupa kind of work done o	lurina most	of working	16b.	Kind of Business	/Industry
7	Athin ne. han	mpi	Elementary/Secondary (0-12)	College (1-	4or 5+)		oo NOT use retired. stered Nu	•		Vio	nna Pedi	istrice
7	led w tygier her ti	ပိ	17. Father's Name (First, Middle, Last)			Kegi	stered No		r's Name (First, Mic			Latites
Maryland 21215-0036	ba fi	To Be	Benjamin Lopez						ra Chavir		in Sumame)	
Ĕ	d Mer mark matic	은	19a. Informant's Name/Relationship (T	ivon Print)		19h Mailir	ng Address (Street a	and Number	r or Bural Boute No	imber City	or Town State	Zin Code)
Ma	d 2 sith an 17 is i		Richard P. Penna		nd.	1	Frog Eye					
e) Je	1 an Heal em 2	1	20a. Method of Disposition	, massar	20b. P	lace of Dispo	sition (Name of		Date		Location - City or	
وَ	ages nt of nt of t: If it		1 Burial 2 Cremation 3 1		tate Hag	emetery, crer terstov	natory or other place vn Cremate	orv :	1/8/04	Hag	erstown	• MD
Baltimore,	parmil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural, or itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinating Institute modified at once.		 4 □ Deflation 5 □ Other (Specify) 21. Signature of Funeral Service Licery 		Ilin.	22	. Name and Addres	s of Facility	/			
B	Dep Pany Puny Puny		barbara A. Wil	liams, (Owner	J	ohn T. Wi	illian Svilla	ns Funera	1 Hom	ie MD	21716
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that ca	used the death						TCK, III	Approximate Interval Between
2	Pnysician		Immediate Cause (Final	III o	1005	Gar	minto	sti	ral F	3/00	odivo	Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (o	as a consequ	uence of):	trointe Colm	- 0	- 7,	(CE C	cury	Deg 5
н	Examiner		Commentative line and distance	b. Ac	duane	sed	Colon	C	ancer	-	~	7 years
-	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a consequ	uence of):						U
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
8760,	oe ax clan a	Ē	Toolking in doday, saos	Due to (o	r as a consequ	derice or).						
87	law requires that the death certificate be axecuted as been signad by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	•	d								
9 ×	ding se as	/Me	IF FEMALE:	23c. If yes, outc	ome of pregna	ncv					23d. Date of del	iver.
Вох	atten for u	cian	in the past 12 months?	1 Live bir	th 2 ☐ Fetal nt at time of de	death 3	Ectopic pregnancy Other (specify)				Month	Day Year
P. O.	that the death certific ad by the attending p detached for use as	ysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknov								
σ,	res that ignad b be deta	by Pt	Part II. Other significant conditions co	entributing to dea	ath but not rest	ulting in the u	nderlying cause give	n in Part I.	23e. [oid tobacco	use contribute to	the cause of death?
rds	quires n sign									☐ Yes	2 1 No 3 □ Pr	robably 4 Unknown
00	aw require as been si 2 should I	Completed								Vas an	24b. Were au	utopsy findings available completion of cause of
æ	Tha lav ate has page 2	E							10 1	iutopsy enformed? es 2∭N	death?	-Mar.
ital		Bec	25. Was case referred to medical					26. Place	of Death (Check o	/-		
)	Physician: r this certific ral director,	To	examiner? 1 ☐ Yes 2 ◯ No	Hospital: 1 □ In	patient 2 🗆	ER/Outpatier	t 3□ DOA Othe	er: 4 ☐ Nur	rsing Home 5 X	Residence	6 □Other (Spe	cify)
0	ng Ph Ifter th Ineral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of (Month	Injury , Day Year)	28b. Time of Injury	Work	(?		ibe how inj	ury occurred	
sio	Attending ir death, ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be					Yes 2□N				
Division of Vital Records,	i Site	Certification:	4 Homicide determined	286. Place 0	g, etc. (Specify	me, tarm, str	eet, factory, office			Town, Sta		ural Route Number,
_	To the Hospital within 24 hours a To the Funarel Completely filled		29a. Certifier 1 Certifying Phy	/sician: To the t	pest of my kno	wledge, death	n occurred at the tim	e, date and	d place, and due to	the cause(s) and manner as	s stated.
	e Hos	edicai	(Check only 2 Medical Examone)		sis of examina							
	withir To th	×	29b. Signature and title of certifier				29c. License		- ((ate signed (Mont	
			1 Kulor	-	かく	186	6 D	41	866	Ja	nuary o	5,2004
	12		30. Name and address of person who o							_		
		1	Dr. Kannan HudHu				oad, Fred	erick	, MD 2170	1		
	Sta Registi		31. Date filed (Month, Day, Year) JAN -	5 2004 >	gistrar's Signa	ture	6 A	parks	2			

			. For	State of Ma							ene	0.1.40
			1 - State Registrar			Certif	ficate of	Death		Reg	. No. 200	+ 01627
			1. Decedent's Name (First, Middle, La.	st)					2. Date Mont	of Death	Day Year	3. Time of Death
	Physici /Medio		Howard Cassius Pa	ine					Janu	ary 3	3, 2004 Year	11:45A™
	Examir		4e. Fecility Name (If not institution, giv	e street and number)		41	b. City, Town, o	r Location of	Death		4c. County of Dea	th
			Buckingham's Choi	ce		A	damstow				Frederi	ck
	Funeral Director		339-32-7241	Sex 7. Age	92		f Under 1 Year lonths Days	If Under 2 Hours	Min. 8. Date (Mon June	th, Day, Y	9. Bi 1911 Ne	thplace (Stete or Foreign ountry) ebraska
	pug ≱ 1		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town	or Locati	ion					10d. Inside City Limits
	/aryi	ō	Maryland Frederic	·k	Adamst	own						1 ☐ Yes 2 No
	28a-	Director	10e. Street and Number				10f. Zip Code			100	. Citizen of What C	ountry?
	With Ba or		3200 Baker Circle	. #A-101			217	10		IIr	nited Sta	tec
	death	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13. Was			in? (Specify Yes Puerto Rican, et		14. Race - Am	erican Indian,
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23s or 28s-f show feurnatic event, Its Madical Evertiner raist be natified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ⊠ Yes 2 □ N If Yes, Give Year or Dates: N	⊌ World		es, specify Cuba Yes 2⊠ No		Puerto Rican, et	c.)	Black, Whi	White
Ō	2 ho	Completed	15. Decedent's E	ducation	16a.	Decedent	t's Usual Occup	ation	of working	16	b. Kind of Business	/Industry
2	P. P. P. P. P. P. P. P. P. P. P. P. P. P	pje	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO	d of work done NOT use retired	d)	or working	I	Federal	
7	gieni gieni erth	NO.	<u> </u>	5+		coun	tant				Governmen	t
2	al Hy	Be (17. Father's Name (First, Middle, Last,					18. Mother	's Name (First, A	liddle, Ma	iden Sumame)	
<u>X</u>	Ment Ment arke	ဥ	Charlie Bruce Pai	_ne					ices Vas			
a	2 shc and is mu		19a. Informant's Name/Relationship (+						City or Town, State,	
2	and ealth 127 rar tr		Joan P. Porter/ I	aughter				n Pike			Marylan	
ore	T ital		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of cemeter	Disposition Cremato	on (Name of ory or other place Towns	^æ ∫Ja	nuary 9		c. Location - City or	Town, Stete
Ē	Par ment		* 4 □ Donation 5 □ Other (Specif	5)	Memori	al Pa	ory or other place Lawn ark		2004	Ro	ckville,	Maryland
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: if item 27 is marked any niury or other treumstic enough.		21. Signature of Funeral exce Lide	M	100689	Betl	hesda-C Bet	hevy C hesda,	hase, In Maryla	nç. nd 20	7557 Wis 0814-3501	ineral Home/ consin Avenu
	0		23a. art Interne disease, or com ho Dr heart failure. List only Immediat Cause (Enal		_ 4	ot enter th	he mode of dyin	ng, such as c	ardiac or respira	tory arres	l,	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)		PINAT a consequence of		FAI	Wrez				10000
	Examiner				umor	-						10 dAS
В		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		а сопѕециеное с							
3760,	ate be executed hysician and he burial-transit	Ical Examiner	cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequence o	of):						
Box 68	leath certificate b attending physic I for use as the b	n/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date of de	livery
о В	that the death led by the atte detached for	by Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death time of death		topic pregnancy ther (specify)	, 			Month	Day Year
π. σ	uires that signed b	y PI	Part II. Other significant conditions	contributing to death be	ut not resulting in	the unde	rlying cause giv	en in Part I.	23e.	Did toba	cco use contribute t	o the cause of death?
rds	auire n sig ald bu	D D	LEREBRO V	'ASCULAN	Accip	EU7	r	,		1 🗆 Yes	2 ₽ No 3□P	robably 4 Unknown
00	s been si should!	Completed				'			24a.	Was an		utopsy findings available
E	The lav	Eo			_				_	autopsy performe	d? death?	completion of cause of
tal	en: 1	0	25. Was case referred to medical					26. Place	of Death Check	Yes 2	2100	2040
>	ysici s cer direct	0 18	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2 ER/Ou	tpatient :	3 DOA Oth	00	And the second second second		ce 6 □Other (Spe	ocify)
0	g Ph er th	n: T	27. Manner of Death	28a. Date of Injur	y 28b. T	ime of	28c. Injur Wor				injury occurred	
<u>ō</u>	ndin ath. r: Aft e fur	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio		7 7 0417			Yes 2□N	0			
Division of Vital Records, P.O.	al or Atts s after des i Directo d in by th	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ury - At home, fai c. (Specify)	m, street,	, factory, office			tion (Street or Town, S	et and Number or R State)	ural Route Number,
	To the Hospital or Attending Physicien: The law requires that the death certificat within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Example)	nysician: To the best of miner: On the basis of and manner sta	examination and	, death oc d/or invest	ccurred at the tir tigation, in my o	ne, date and pinion, death	place, and due to occurred at the	o the cau time, date	se(s) and manner a a and place, and du	s stated. e to the cause(s)
	To th withir To th comp	M	29b. Signature and title of certifier				29c. Licens	e number		29d	. Date signed (Mon	th, Day, Year)
)	142,) The	MARKE	och w		1	D-31	912		1/05/2	200 4
	13		30. Name and address of person who				nt)				., 0 - /	
			JULID MEMOCAN , nº		Upollow			£ 6	MEDS PL	LH	mp 7	50712
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	4	hoark					
	Regist	rar	JAN 0 6 20	104 Sine	was to	1 ,	By Oak	at the				

		For amend 1te 1-State amend 1te Registrar 1. Decedent's Name (First, Midd		Car1		icente						2. Date of	Death			3. Time of De
Physici /Medic		- Carlos			V	P	laci	ios				Janua) 2004	Year 4	10:40
Examir	4	4a. Fecility Name (If not instituti	on, give s	treet and nu	mber)		4	b. City, T	own, or	Location	of Death		4	4c. County of	of Deat	th
	÷,	Casey House Mo						Roc		11e	24 110	1000		Montgo		
Funeral Director		5. Social Security Number 610-60-3233	6. Sex	M 2□F	7. Age (In y 39				Days	Hours	Min.	8. Date of (Month, Oct.1)	Day, Yea	64 E	Co	thplace (State or F buntry) Salvador
and the		Usurel Residence of Decedent			140-	- T										
show	-	Maryland Mont	*	~W		. City, Town Gaithe										10d. Inside City
28a-f	Funeral Director	10e. Street and Number	50					10f. Zip C	ode.				10a (Citizen of W	hat Co	
Se or	ă	82 West Deer	Park	Road.	#204			208						Salva		,
ms 2:	nera	11. Marital Status		12. Was Dec	edent Ever in	n U.S.	13. Wa			spanic O	rigin? (Sp	ecify Yes or Rican, etc.)		14. Race	- Ame	erican Indian,
"natural", or Items 23a or 28a-f show edical Exteriner must be notified at	/ Fur	1⊠Never Married 2☑ Ma		Armed Fo 1 ☐ Yes If Yes, Gir	2 X No			es, specif Tyes 21				Hican, etc.) Vadora		Specify:	white White	
ural".	d by	3 Widowed 4 Divorce	1	Year or D	ates:						, рат	vadora				
nation	lete	15. Decede (Specify only high	ent's Educ	completed)		16a.	(Give kin	nt's Usual nd of work NOT use	done o	turina mo	st of work	ing	16b.	Kind of Bus	siness/	Industry
al Hygiene. I other than 'vent, the Me	Completed	Elementary/Secondary (0-12))	College (1-4or 5+)	C		enter		,			Coi	nstruc	ctio	on
f Health and Mental Hygiene. item 27 is marked other than other traumatic event, the M	BeC	17. Father's Name (First, Middle	e, Last)							18. Moth	er's Nam	e (First, Mid	dle, Maid	en Surname	9)	
Aental rked o	5 B	Vicente			Pa	alacio	s			1	Maria	ı		Cast	ro	
and Mental		Alba Antonia	nship (Ty)	pe, Print) ez de	Palaci	ios 19b.	Mailing /	Address (Street a	and Numb	er or Rur	al Route Nu	m <i>ber, Cit</i> y	y or Town, S	State, 2	Zip Code) 1877
Department of Health a Important: If item 27 Is any injury of other tra	1	Alba C. Palacio	iw/ac	fe		82	West	: Dee	r P	ark I	Road,	#204	, Ga:	ithers	sbui	r Maryla
i ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	n 3 □R	emoval from	State	•	y, cremat	tory or oth	er plac		Janua			Location - 0		
OF IT IT		`4 ☐Donation 5 ☐ Other	(Specity)		A	111 So						2004			-	Marylan
Depar mpor iny in		21. Signature of Funeral Service	e License		400092)	Bet	hesd:	Addres a-C	s of Facil hevy	ty Rob Chas	ert A.	e Pum	iphrey 557 Wi	Fu	neral Ho onsin Ave
		23a. Part1. Enter the disease,	or compli			-	Bet	nesa	a, .	Mary.	Land	20814				
		Zoa. I arti. Eritor trio discaso,				death Don	ot enter t	the mode	of dvin	n such a			v arrest			Approximate
		shock, or heart failure. Li	st only on	e cause on e	each line.			the mode	of dyin	g, such a			y arrest,			Approximate Interval Betwe Onset and De
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		1 - For State Registrar	State of Ivia		rtificate of Dea			ene 2 (g. No.	104	0162
Physi	cian	Decedent's Name (First, Middle, Last	st)			-	2. Date of Death Month	Day	Yeer	3. Time of Death
/Med	lical	JOSEPH		PASTORE	45 G 5		JAN.	6, 2	004	2:33 P M
Exam	iner	4e. Fecility Name (If not institution, given LAUREL REGION		r	4b. City, Town, or Loca			4c. County		
Funera	1	5. Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Year If U	Inder 24 Hrs.	B. Date of Birth			EORGES place (State or Foreign ntry)
Directo		123-12-2138 Usual Residence of Decedent	XM 2□F	87 Yrs.	Months Days Ho	ours Min.	(Month, Dey, DEC. 2,		NEW NEW	YORK
yland		10a. State 10b. County		10c. City, Town or Lo	ocation				1	10d. Inside City Limits
e Mar	ctor	MD. PRINCE	GEORGES		LANHAM					1 X Yes 2 □ No
or 28	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of V	What Cour	ntry?
sath v	ia		K RD. #1		2070				.S.A.	
laryiand 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumalic event, the Medical Examin arrings by Juditied at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Tyes 2 M No If Yes, Give Year or Dates:		Was Decedent of Hispan If Yes, specify Cuban, Me 1 ☐ Yes 2 X No Sp		fly Yes or No- can, etc.)		ck, White,	
5-00	ted	15. Decedent's Ed	ducation	16a. Dece	dent's Usual Occupation		1	6b. Kind of Bu		HITE dustry
21215-0036 d within 72 hours aff giene. or than "natural", or the Medical Eratul	Completed	(Specify only highest gra	College (1-4or 5+	life	kind of work done during DO NOT use retired)					
Nobe	S	17 Falbada Norra (First Middle 1 and	2		COURT REPO				PRIV	/ATE
Maryland of 2 should be file lith and Mental Hy 27 is marked othe	Be	17. Father's Name (First, Middle, Last) EUGENE	PASTORE		18. 1	Mother's Name (
should nd Men marke marke	2	19a. Informant's Name/Relationship (19b. Maili	ng Address (Street and N	AN		PELU:		Codel
and 2 and 2 nauth ar n 27 is	1	ſ	ALEK/DAUGHT		VERONA DR.,					
or te de la la la la la la la la la la la la la		20a. Method of Disposition		20b. Place of Dispo	esition (Name of matory or other place)	Dat		Oc. Location -		
Pages ment of ant: If it ury or o	2	1 ☐ Burial 2 X Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		,	CREMATORY	1-7-20	04	RIVERI	DALE.	MD.
Baitimore, Maryla permit. Pages 1 and 2 should Department of Health and Men Importent: If Item 27 is marke any injury or other traumatic		21. Signature of Funeral Service Licen	amberd	M00091 2	Name and Address of F CHAMBERS FUN 801 CLEVELA	Facility IERAL HOI ND AVE.	ME & CRI	EMATOR	TIM. P	P. A .
Ş		23a. Part1. Enter the disease, or companies shock, or heart failure. List only	olications that caused the	e death. Do not ent	er the mode of dying, suc	ch as cardiac or r	espiratory arres	st,	H) . Z	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition			SPHERIC INF	ARCTTON				Onset and Death
/Medica Examine		resulting in death)	Due to (or as a	consequence of):						
		Sequentially list conditions, if any, leading to immediate		RTERY DIS	EASE					
68 / 60, rtificate be executed ng physicien and as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c ATRIAL FI		Γ					<u> </u>
68 / 6U, ificate be expression as the buria		l l		HYPERTEN	ISTON					
68 / tificate ig phys	ledicai		d. PELIGIAN	HILEKIEN	ISTON					
death ceideath Physician/M	iF FEMALE: 23b. Was decedent pregnant b. Was decedent pregnant c. 1 □ Yes 2 □ No c. 2 □ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir 9□ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delive nth	ory Day Year	
- E D S	by Pi	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying cause given in F	Part I.	23e. Did toba	cco use contr	ibute to th	ne cause of death?
w requires to been signer should be	ed	CORONARY ARTERY	DISEASE OF	MULTIPLE	VESSELS		1 ☐ Yes	2 🗆 No	3 🗌 Prob	abiy 4 🛣 Unknown
HeC he law e has b	Completed						24a. Was an autopsy performe	ed? d	Vere autor rior to con eath?	psy findings available appletion of cause of
ysician: Tysician: Be C	25. Was case referred to medical examiner?			26. F	Place of Death (C		2140			
Of VITA Physician: this certific ral director,	2	1 Yes 2 No	Hospital: 1 Xnpatient	2 ER/Outpatien		Nursing Home				')
ding After fune	Certification:	1X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes		Describe how	injury occurre	ed	
INISION or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not be		- At home, farm, str			Location (Stre	et and Numbe	r or Rural	I Route Number,
in Digital	Serti	4 Homicide	building, etc.	Specify)	,,		City or Town,	State)		7.0010 7.077001
Hos Fun 4	edicai (29a. Certifier 1 XCertifying Phy (Check only one) 2 Medical Exam	ysician: To the best of r iner: On the basis of ex and manner state	tamination and/or inv	occurred at the time, dat restigation, in my opinion,	te and place, and , death occurred	due to the cau at the time, date	se(s) and mare and place, a	ner as stand due to	ated. the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier		^	29c. License numi	ber	290	. Date signed	(Month, L	Dey, Year)
20		> SRUU	Mar. M	D	D21:	200		JAN.	6, 20	004
7		30. Name and address of person who compared the SHRINIVAS R			Print)	R PKWY.,	GREENE			
	ate	31. Date filed (Month, Day, Year)	32. Pegistrar's		,			FI		
Regis	trar	JAN 08 200	14 Sener	20	Sparks					

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and	-	•	
		1	1 - State Registrar Certificate of Death		Reg. No. 200	4 0 1 6 3 0
Phy	sicia		1. Decedent's Name (First, Middle, Last)	2. Date of Dea	Day Yeer	3. Time of Death
/M	edica	al -	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea	JAN,	1, 2004 4c. County of Dea	
Exa	mine	er :	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Det 4c. City, Town, or Location of Det 4c. City, Town, or Location of Det		Now	
Fune	rai		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr	rs. 8. Date of Birt		rthplace (State or Foreign ountry)
Direc			291-74-6064 1XM 2 F 74 Yrs. Months Days Hours Min	4-16-1	929 I	ndia
pu *		-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryli f sho		ō	MD Howard Columbia			1 ☐ Yes 2 ☐ No
r 28a		Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	ountry?
th with		aiD	7323 Kerry Hill Ct. 21045		U.S.A.	
r dea		Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Whi	
36 rs afte		by Fi	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☒ No Specify: Year or Dates:		Specify: A	sian-Indian
1215-0036 within 72 hours after death with the Maryland one. then "natural", or items 23a or 28a-f show					16b. Kind of Business	s/Industry
215		piet	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of w	vorking		
21 ed wii ygien th	9	Completed	4 Accountant			s/Blue Shield
be fill had be fill had be out		Be	17. Father's Name (First, Middle, Last) Puthukunanthan 18. Mother's Name (Paridunanthan)	lame <i>(Fir</i> st, <i>Middl</i> e, ranam	Maiden Sumame)	
ryla hould d Mer marke		ဥ	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number or It</i>		ar, City or Town, State.	Zin Code)
Ma nd 2 s lith an 27 ls			Sherwine P. John - Daughter 925 High Stepper Tra			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be lifed within 72 hours all Department of Health and Mental Hygiene. Importent: If them XT 18 marked other then "natural", or important: other teaments area.	0		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City of	r Town, State
Page Page hent c	54		1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) Geo. Wash. Cem. 1-4-	-04	Adelphi, M	D
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. "Institutal, or Hems 23a or 28a-1 show Important: If tiem 27 its marked other then."	9		21. Secarcife of Fune all Second License 22. Name and Address of Facility	Hines-Rin	aldi F. H.	
m goe:	6 0	1	11800 New Hampshi	re Ave.,	Silver Spr	ing, MD 20904 Approximate
			23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi shock, or heart failure. List only one cause on each line.		rest,	Interval Between Onset and Death
Physici /Medi			Immediate Cause (Final disease or condition resulting in death) a. Alorte myseconds infruction Due to (or as a consequence of): Coronary artiful disease			1 /2
Examir	-		Due to (or as a consequence or):			appeal JA
		Jer	Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			serve 7.3
cuted	100	Examiner	that initiated events C.			
760, te be executed ysician and	8		resulting in death) Last Due to (or as a consequence of):			[
5 8 8	9	dicai	d			
The law requires that the death certifica the has been signed by the attending physical property of the second for the second	10 10	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of de	elivery
that the death certified by the attending		iciar	in the past 12 months? 1 Vee: 2 No. 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
by the	200	hys	9 Unknown			
ds, P. uires that signed b	9 9	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute t	
Cord * requir been si	200	ted	Insulis dependent dealete Hellies	- 101		robably 4 □Unknown
lec law has b	N C	npie		24a. Was autop	an 24b. Were a prior to death?	utopsy findings available completion of cause of
Th. Th.	, pag			1 ☐ Yes	2 No 1 □ Ye	s 2□No
of Vital Rec Physician: The law r this certificate has t	O L	o Be	examiner?	eath (Check only o	ne) dence 6 ⊡Other (Spi	eciful
D Phys	ris	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		now injury occurred	sony
Vision Attending r death. ector: After	9	atio	2 Accident investigation M 1 Yes 2 No			
Division of Vital Records, alor Attending Physician: The law requires later death. Director: After this certificate has been signs.	n do t	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tox	Street and Number or F vn, State)	Rural Route Number,
Div Hospital or 14 hours afte Funerel Dire	De	Ce		, and due to the		d
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After	etely 1	edicai	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)			
To the within To the	duo	Me			29d. Date signed (Mon	th, Day, Year)
1_	-		D37777		JON 32	d. 2004
0			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		MD 210	
		Ŋ.	PETER CHERY 2 KNOW WORTH DV. COLL	IMBIA	MD 210	4
Re	Sta gistr		JAN 0 6 2004 32. Registrar's Signature Aparka			
110	J. C.		JHILD O TOOL AND AND AND AND AND AND AND AND AND AND			

			For State Registrar	State	of Marylar		artmen				lental Hy	gien Reg. N	2001	0 . (531
	Div		1. Decedent's Name (First, Middle	Last)							2. Date of De		ay Yeer	3. Time of	Death
	Physici /Medio		BRUCE G. PHILIP	SON							JANUAR			9:10	P^{M}
	Examir		4a. Fecility Name (If not institution,	give street and n	umber)		4b. City,	Town, or	Location	of Deeth		40	c. County of Death		
			HEBREW HOME OF				ROCKV			0411-	,		ONTGOMERY		
	Funeral		5. Social Security Number 577-32-7802	6. Sex 11∑1 M 2 ☐ F	7. Age (In yrs.		If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da	ay, Year	9. Birthp	lece (State o	r Foreign
	Director		Usual Residence of Decedent		1	76 Yrs.					OCT. 2	4,	1927 WASH	ÍNGTON	DC
	land ow		10a. State 10b. County		10c. Ci	ity, Town or L	ocation					-	1	0d. Inside Ci	ty Limits
	Man	ţō	MARYLAND MONTGO	MERY	BET	THESDA							,	1 X Yes	2 🗌 No
	h the	irec	10e. Street and Number		1		10f. Zip	Code				10g. C	itizen of What Cour	ntry?	
	death with the Maryland me 23a or 28a-f ahow frount be notified at	Funeral Director	7004 MARBURY RO	AD			20	817				U. S	S.A.		
	dea	ner	11. Marital Status	12. Was De Armed F	cedent Ever in U	J.S. 13.	Was Deced	dent of Hi	ispanic Ori	gin? (Sp	ecify Yes or No Rican, etc.))-	14. Race - Americ Black, White,		
98	or it	Fu	1 Never Married 2 X Marri		2 💢 No		1 Yes		Specify:		1110411, 010.7		Specify: WHI		
Ö	72 hours after natural, or ite	d by	3 Widowed 4 Divorced	Year or	Dates:							,			
21215-0036	n 72	Completed	15. Decedent (Specify only highes)	(Give	dent's Usua kind of wo DO NDT us	rk done d	<i>during</i> mos	t of work	ing	16b. I	Kind of Business/Ind	dustry	
12	within lene. than	E	Elementary/Secondary (0-12)	College 5+	(1-4or 5+)		IFIED		_	CCOU	NTANT	ACCO	OUNTING		
	Hyg other	Be C	17. Father's Name (First, Middle, L	ast)			· · · · · · · · · · · · · · · · · · ·				e (First, Middle	, Maidei	n Sumame)		
lar	ald be Aenta rked tic a	To E	ROBERT	P	HILIPSON	V.			LILL	IAN			GLUECK		
Maryland	2 should and Men is marke		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mail	ing Address	(Street a	and Numbe	er or Run	al Route Numb	er, City	or Town, State, Zip	Code)	
	and ealth m 27	1 0	SELMA B. PHILIP	SON/WIFE					ED., 1		ESDA, M				
ore	Pages 1		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from	n State	Place of Disp cemetery, cre	matory or o	ther plac			Date		ocation - City or To		
Baltimore,	then then tant:	١.,	'4 Donation 5 Other (Sp		GA	The second second							RKSBURG,		AND
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f ahow any injury or other traumatic avent, the Macinal Examination and pages.		21. Signature of Funeral Service L	. Oto	Memy								N, INC E, MD 208	52	
r			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that only one cause on	each line.		81 -		g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Bety Onset and D	Meen
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a.	Jon-t		Kin	5 1	ym	M	oma			0.100, 2.10	
P	Examiner			Due to	o (or as a consec	quence of):			J	•					
		er	Sequentially list conditions, if any, leading to immediate	b. Due to	o (or as a consec	quence ot):									
	outed od ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. ====											
Ő,	ate be executed thysician and the burial-transit		resulting in death) Last	Due to	o (or as a consec	quence of):									
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dicai		d									1 0		
9 x	that the death certific: ed by the attending pl detached for use as t	Physician/Med	IF FEMALE:	23c If yes o	utcome of pregn	ancy									
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2 Feta	aldeath 3	□Ectopic pr □ Other (sp						23d. Date of delive Month	2	ear ear
P.O.	the d	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unk		u g an 51	_: Other (sp	ecny)							
	res that signed b be deta	by Pt	Part II. Other significant condition	ns contributing to	death but not res	sulting in the t	inderlying c	ause give	n in Part I.		23e. Did t	obacco	use contribute to th	e cause of de	eath?
Records,	w require: been sig should b	q pa									10	Yes 2	No 3□ Prob	abiy 4 □U	nknown
000	aw requas been 2 should	piet									24a. Was		24b. Were autor	osy findings a	available
	The ate h page	Completed									autor perfo	ormed?	death?	npletion of ca 2□ No	luse or
Vital	icien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o		, , , , , , ,		
of <	Physic this co	2	1 ☐ Yes 2 ☑ No		Inpatient 2	ER/Outpatie			4. S PRU	rsing Ho	me 5 ☐ Resi	dence	6 □Other (Specify	7	
n O	ding Ph h. After th funeral		27. Manner of Death 1 Senatural 5 ☐ Pending	28a. Date (Mo	of Injury nth, Day Year)	28b. Time o		8c. Injury Work			28d. Describe I	how inju	iry occurred		
sio	Attending Phyaicien: er death. rector: After this certificity the funeral director.	icati	2 Accident investign 3 Suicide 6 Could n	ot be			M		/es 2 □ l	-	006 1	O4			
Division	after after Direction by	Certification:	4 Homicide determine	ned 200. Flat	e of Injury - At h ding, etc. <i>(Speci</i>	fy)	reet, ractory	г, опісе			City or To		nd Number or Rura. e)	Houte Numb)07,
_	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying (Check only 2 Medical 8	Physicien: To the xaminer: On the	ne best of my kno	owledge, dea	th occurred	at the tim	e, date an	d place,	and due to the	cause(s	s) and manner as st d place, and due to	ated.	
	the I	Medical	Sile)	and ma	nner stated.										
			29b. Signature and title of certifier	MA	1	MIN	3	: License	GII			290. Da	ate signed (Month, I	Day, rear)	, ,
	10		30 North	wa	upun	17(1)	2	107	74	<u>_</u>		JM	V 5	200	4
			30. Name and address of person v	no completed car	ose of death (Ite	MAD (Type	612	1 1	Yout	8050	· 12d	D	ockville	MAT	>
	Sta	te	31. Date filed (Month, Day, Year)		Registrar's Signa	ature	1		(-/1/		~1	-	CHAILA	1012	
· ·	Registr	ar	JAN 0 7	2004	seren	19	ppe	aks	/						

		4	State 1 - State 1 - Registrar	of Maryland / Dep ,f, per FH,GB	artment of Health and 32,07/18/04dhb rtificate of Death	Mental Hygiene	2004 01632
		報	Decedent's Name (First, Middle, Last)			2. Date of Death Month Day	3. Time of Death
	Physici /Medic	_	DOROTHY E.	PIATT		Jan. 7,	2004 4:16P M
	Examir		4a. Facility Name (If not institution, give street and n	number)	4b. City, Town, or Location of Deat	h 4c.	. County of Death
			Casey House	7 4 //2 / / /	Rockville	I D	Montgomery
12	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday, Yrs.	Months Days Hours Min.	(Month, Day, Year)	
			167-22-7331 Tusual Residence of Decedent	76		Nov. 24, 19	927 Pennsylvania
	rylanc how		10a. State 10b. County	10c. City, Town or L		a .	10d. Inside City Limits
	Ba-f e	cto	MD Montgomery		esville Silver		1 Yes 2 □ No
	or 2	Director	10e. Street and Number 8505 Springv	ale Rd. #245	10f. Zip Code		izen of What Country?
	72 hours after death with the Maryland natural', or flems 23a or 28a-f ehow ilical Exchains must be mailled at		17311	and and Service U.S. Land	20837 2093		
	iten de	Funeral	Armed	pedent Ever in U.S. 13. Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	 Race - American Indian, Black, White, etc.
920	urs af	by F	3 ☐ Widowed 4 ☑ Divorced Year or	Sive	1 ☐ Yes 2 ☐ No Specify:		Specify: White
21215-0036	72 hours natural', ical Ex	ted	15. Decedent's Education		dent's Usual Occupation skind of work done during most of wo	16b. K	ind of Business/Industry
21	⊆ 3	Completed	(Specify only highest grade completed Elementary/Secondary (0-12) College	(1-4or 5+)	DO NOT use retired)	rking	
21		S	12th	Own	er-Operator		Dairy Queen
and	Z E Z	Be	17. Father's Name (First, Middle, Last)			me (First, Middle, Maiden	,
Z Z	d 2 should by th and Menta 7 le marked traumatic ev	ဥ	James Emory 19a. Informant's Name/Relationship (Type, Print)	10h Maili	ng Address (Street and Number or Ri	na Saunder	
Maryland	hall 7 le		Nancy Swank - Daug		44 Fisher Ave		
	s 1 and 2 f Health Item 27 other tra		20a. Method of Disposition	20b. Place of Dispo	osition (Name of	The second secon	ocation - City or Town, State
SE.	8 = 5		X☐ Burial 2 ☐ Cremation 3 ☐ Removal from 14 ☐ Donation 5 ☐ Other (Specify)		nion Cem 1/1	2/2004 Hur	ntington, PA
Baltimore,	그문문증기		21. Signature of Funeral Service Licensee	/ 2	2. Name and Address of Facility S	nowden Fur	neral Home. PA
m	Departiment of the particular		Teorge X Sur	//			ville, MD 20850
			23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause or	t caused the death. Do not en n each line.	ter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between
	Physician	r Y	Immediate Cause (Final disease or condition ENI	STAGE CHRO	NIC OBSTRUCTIV	E PULMONA	Onset and Death RY DISEASE 6mths
	/Medical Examiner		resulting in death) Due t	o (or as a consequence of):			
	Examine	_	Sequentially list conditions, b.	o (or as a consequence of).			
	ted nsit	all l	cause. Enter Underlying Cause (Disease or injury	o (or as a sorresqueries or).			
<u>,</u>	be executed sician and burial-transit	Examiner	that initiated events c.	o (or as a consequence of):			
8760	death certificate be executed e attending physician and of for use as the burial-transit		d				
9	ntifica ng ph as th	Physician/Medical	IF FEMALE.				
Вох	eath certific attending pl	an/l		outcome of pregnancy birth 2 Fetal death 3	□Ectopic pregnancy		23d. Date of delivery Month Day Year
O.		scl	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unk		Other (specify)		Month Day Year
۵.	that the		Part II. Other significant conditions contributing to	death but not resulting in the u	inderlying cause given in Part I	23e. Did tobacco u	use contribute to the cause of death?
Vital Records,	P P P	d by			moony my occasio giron in race.	1 ☐ Yes 2	
Sor	w r-quir been si sh, uld	ete			-	24a. Was an	24b. Were autopsy findings available
He	he lav	Completed				autopsy performed?	prior to completion of cause of death?
ta		ပိ	25. Was case referred to medical		26 Place of Do	1 ☐ Yes 2 ☐ No	1 Yes 2 No
	Physiclan: this certific ral director,	0 B	examiner?	Inpatient 2 ER/Outpatie	0.1		6 NOther (Specify) Hospice
٥٥		T:U	27. Manner of Death 28a. Dat	e of Injury 28b. Time onth, Day Year) Injury		28d. Describe how injur	
jo	Attending I r death. ector: After by the funer	atlo	2 Accident investigation	, 20, 100,	M 1 Yes 2 No		
Division	- 9	Certification:		ce of Injury · At home, farm, st Iding, etc. (Specify)	reet, factory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,
	oital ours af					1	
	Hospital 24 hours a Funeral I	edical	(Check only 2 Medical Examiner: On the	he best of my knowledge, deat basis of examination and/or in anger stated.	h occurred at the time, date and place vestigation, in my opinion, death occu	e, and due to the cause(s) arred at the time, date and	and manner as stated. I place, and due to the cause(s)
	To the Hospital o within 24 hours aff To the Funeral Di completely filled it	Mec	29b. Signature and Title of Certifier	Stated.	29c. License number	29d. Dat	te signed (Month, Day, Year)
	1.5		VI SHILL	~	DA 54112	18 01	1/08/04
	10		30. Name and address of person who completed ca	use of death (Item 23a) (Type,	Print)	-0	-10010-1
_			Mr. Charles Harriso	on, MD 6001	Muncaster Mill	Rd Rockvi	ille, MD 20850
	Sta		31. Date filed (Month, Day, Year) 32.	Registrar's Signature	Sparks		
	Registi	ar	IAN 0 9 2004	Depart 1	KINOUKU		

			1 - For State Registrar	State of Maryla	nd / Depa		lealth and N	Mental Hyg	giene Reg. No. 20	04 01633
7	Physici /Medi Examir	cal	Decedent's Name (First, Middle, Last Ginette Ali Fecility Name (If not institution, give 7420 Westlake Ter	ce Maria	Poen		Location of Death	2. Date of Dea Month Jan.	4 200 4c. County o	Death
	Funeral Director		Social Security Number 6. Security Number		: last birthday) Yrs.		Il Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March	Montgo (1, 1930	
	hours after death with the Maryland turel', or Items 23e or 28a-f show al Examinar must be notified at	Director	10a. State 10b. County Maryland Montgome 10e. Street and Number		ethesda			1.	l 0g. Citizen of Wi	10d. Inside City Limits 1 ☐ Yes 2∑ No
' 0	be filed within 72 hours after death with the Marylan Ital Hygiena. Id other than "naturel", or Items 23e or 28e-f show event, the Medical Examiner must be notified at	Funeral Di	7420 Westlake Terr 11. Marital Status 1 Never Married 2 Married	ace #1302 12. Was Decedent Ever in UArmed Forces? 1 □ Yes 2 □ No	J.S. 13.	20817 Was Decedent of H II Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto		United	•
15-0036	within 72 hours al ons. then "neturel", or	Completed by	3 ☑ Widowed 4 □ Divorced 15. Decedent's Edu (Specify only highest grad	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No dent's Usual Occup kind of work done of DO NOT use retired	Specify: ation during most of work	ing	Specify:	White iness/Industry
Maryland 21215-0036	ould be filed withi Mental Hygiena. arked other than atic event, ma M	Be	17. Father's Name (First, Middle, Last) Marcel Domini	College (1-4or 5+)	H	lair Styl:		e (First, Middle,	Maiden Sumame	vate
	permit. Pages 1 and 2 should be Department of Health and Menta Important; if item 27 is marked eny injury or other treumatic a once.	To	19a. Informant's Name/Relationship (Ty Viviane Durand	ype, Print) d (Daughter)	19b. Mailir P1an La Ro	ng Address <i>(Street</i> Ravier Bl chette	and Number or Rur	al Route Number	chapelet r, City or Town, S	tate, Zip Code)
Baltimore,	nit. Pages 1 andment of Hi ortant; if iter injury or oth		20a. Method of Disposition 1 Burial 2 ACremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	Removal from State C1	cemetery, crer hesapea	sition (Name of matory or other place in the Cremator). Name and Address	ory Jan.		20c.Location - C Beltsvil	ity or Town, State Le,MD
Ba	Dep Imp eny eny		23a. Part1. Enter the disease of compleshock, of heart lailure. List only or	lications that caused the dea	Ra 93	pp Funera 3 Gist Av	al And Cr renue Sil	emation ver Spri or respiratory arr	Services ng, MD est,	Approximate Interval Between
22 38	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Lui Due to (or as a consec	ng Canc	er				Onset and Death 2 Years
760,	icate be executed physicien and s the burial-transit	ical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect Due to (or as a consect Due to (or as a consect						
O. Box 68	death certil e attending d for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date Monti	•
ecords, P	The law requires that the te has been signed by thoage 2 should be detache	by	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the u	nderlying cause give	on in Part I.			ute to the cause of death? Probably 4 □Unknown
Vital Rec	(0)	e Completed	25. Was case referred to medical				00 Bloom of Book	24a. Was a autops perform	y prie ned? dea No 1	ere autopsy findings available or to completion of cause of ath? I Yes 2 \(\text{No} \)
0	Phys this ral di	ation; To B	examiner?	lospital: 1 Inpatient 2 Inpatient 2 Albare of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	4 I radising no	me 5⊠Reside	ence 6 Other	
Division	or At after of Direction by	Certification;	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	fy)			City or Town	, State)	or Rural Route Number,
	To the Hospital within 24 hours and to the Funeral completely filled	Medical	29a. Certifier (Check only one) 1 ⚠ Certifying Physical Examinate (Check only one) 29b. Signature and title of certifier	ner: On the best of my kno ner: On the basis of examina and manner stated.	ation and/or inv	estigation, in my op	inion, death occurr	ed at the time, da	ate and place, and	d due to the cause(s) Month, Day, Year)
	100	1	30. Name and address of person who co	Impleted cause of death (Iter	m 23a) (Type.	D29675			an. 6, 2	
- 5	Sta		Ralph Boccia, M. 31. Date liled (Month, Day, Year)	D. 6420 32. Registrar's Signa	Rockled	lge Dr. Si		Betheso	la M.D.	20817
30	Registr	ar	JAN 09 200	14 Jenera	4	South	/			

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

				State of Ma	aryland	•	nent of r icate of			giene _{Reg. No.} 20	04	01634
	Physicia	ın	1. Decedent's Name (First, Middle, Last,						2. Date of De Month	Dev	Year	3. Time of Death
1	/Medic	al .	FLORENCE 4e Fecility Name (If not institution, give	street and number)	Р	OWELL		4b. City. Town, or	Jan.	4,20		5:30AM
2	Examin	er	Randolph Hills		g Hom	1e		Silver	Spring		tgon	nery
	Funeral Director		220-30-5718	7. Age 9.	e (In yrs. lest]		Under 1 Year onths Days	If Under 24 Hrs Hours Min.	(Month, Da	th ly, Year) 16,1912	9. Birthpl Count Mar	ace (State or Foreign try) Yland
	/lend		Usuel Residence of Decedent 10e. Stete 10b. County		10c. City, T	own or Location	on				10	Od. Inside City Limits
	e Man	ctor	MD Howard			Columb	oia					1 □XYes 2 □ No
	ith th	Die	10e. Street end Number				Of. Zip Code			10g. Citizen of W		ry?
	a 23a	eral	6536 Quiet Hou	S C	Ever in II S	12 Was		LO45	pacifu Vas or No	U.S	· A .	an Indian
020	urs after d	by Funeral Director	1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 X N If Yes, Give Year or Dates:			s, specify Cub	Hispenic Origin? (Sen, Mexican, Puerl Specify:	to Rican, etc.)	Black Specify:	c, White, e	
Maryland 21215-0020	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at page.	Be Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cetion e <i>completed)</i> College (1-4or 5		life. DO ∧	s Usual Occup of work done NOT use retired	petion during most of word d)	rking	16b. Kind of Bu		ustry
7	Hygier ther th int, the	<u></u>	7th 17. Father's Name (First, Middle, Last)	18 Mother's Nar	ne /First Middle	HOI Maiden Sumame						
<u>a</u>	d be i	To Be		well						hompson	•	
lary	end M a mer	-	19a. Informant's Name/Relationship (Ty		and Number or Ru							
∑ o`	and in many many many many many many many man	-	Mary Myers - C	ousin	House		bia, MI					
Baltimore,	mant of himman of himman of himman of himman of himman or other himman or othe		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ R 1 □ Opnation 5 □ Other (Specify)		ce) Cem	Date L/9/04	Sandy		ing, MD			
Bal	Dependit	4	1. Signal re of Funeral Se incense	Sign	w.d/	1	me and Addre	ess of Facility ashingt				Mome, PA MD20850
in the second	Physician		23a. Part1. Enter the ase ase, or complishock, or hear fure. List only or	cat in that caused te cause on each lin	the death. D	Do not must the	e mode of dyir	ng, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
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ă Œ	daath he atta ed for	Physician/N	Part II. Other significant conditions con	tributing to death bu	ut not resultin	g in the underl	ying cause giv	en in Part I.	23b. Did	tobacco use con	tribute to	the cause of death?
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	V	-	30. Name and address of person who co					. ,		20005		
			Martin Shargel, 31. Date filed (Month, Day, Year)		0 Far		Ave 1	Kensing	ton, MI	20895		
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Department of Health and Mental Hygiene. Important: or Itams 23a or 28e-f show any injury or other treumstic event, It a Madical Examinar must be notified at once.	Director	10e. Street and Number			10	of. Zip Code			10g. Citiz	zen of What Co	untry?
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		•	1 - For State Registrar	State of Ma	ryland		ırtment <i>tificate</i>			and Me	-	giene Reg. No	2001	01636
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	Examir		4a. Fecility Name (If not institution, give st Northwest Hos 5. Social Security Number 6. Sex	pital	(In yrs. las	t histoday)	Ran	dal	Location o	wn	B. Date of Bir	E	County of Dea	ore
	Funeral Director		218-32-1526 Usual Residence of Decedent	7. Age	85	Yrs.	Months	Days	Hours		pec. 1,	191	8 Mai	thplace (State or Foreign ountry) Cyland
	vith the Marylan t or 28a-f ehow be notified at	Director	10a. State 10b. County MD Carroll 10e. Street and Number 7309 Second A		_	Town or Loo Cesvi	.11e	Code 2178	A	·		10g. Ci	tizen of What C	
9036	72 hours after death with the Maryland netural; or items 23s or 28s-1 ehow dical Exicolities and be notified at	d by Funeral		2. Was Decedent E Armed Forces? 1 Yes 2XN If Yes, Give Year or Dates:				ent of His ify Cubar	spanic Orig n, Mexican	gin? (Spec i, Puerto R	ify Yes or No ican, etc.)) -	14. Race - Am Black, Whi	erican Indian,
Maryland 21215-0036	I within piene.	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)			16a. Deced (Give I life. L Neve	kind of wor OO NOT us	k done di e retired) plo	uring most yed				ind of Business	/Industry
yland	d la b	To Be	17. Father's Name (First, Middle, Last) Unknown						Unk	nown				
	ges 1 and 2 should it of Health and Mer if item 27 ie marke or other traumatic		19a. Informant's Name/Relationship (Type Stephen Held 20a. Method of Disposition	ə, Print)	20b. Plac		Hof	fma			d., M	iill	ers, Nocation - City or	ID 21102
Baltimore,	it. Partimentrant:		1 Ži Burial 2 ☐ Cremation 3 Ži Re 1 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Fineral Service Licens	A	Zicen	n (Sh heran	affe Ceme	ris) eter	y ↓2 s of Facility	Jan. 2004	22,	Sev	en Val	leys, PA
Ba	permi Depa Impo Impo any ii		23a. Pert1. Enter the disease, or complic shock, or heart failure. List only she	hit	the death.	J 2	J. 4 Sec	Hart cond	ens	tein N	Mort ew Fr	uar eedi	y, Inc	17349 Approximate Interval Between
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Division	tal or Attenirs after deat al Director:	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc.		e, farm, stre	et, factory,	office		28	8f. Location (City or To			ural Route Number,
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	edicai	29a. Certifier 1 Certifying Physi (Check only one)	cian: To the best o er: On the basis of and manner stat	examinatio	edge, death n and/or inv	occurred a restigation,	at the time in my opi	e, date and inion, deat	d place, an	d at the time,	date and	d place, and due	e to the cause(s)
	To the within 2 To the complet	W	29b. Signature and tifle of cartifier	in h	W			De	number [4 J	U8"		29d. Da	te signed (Mont	1, Dey, Year) 3 19,200 Y
		10	30. Name and address of person who con 31. Date filed (Month, Day, Year)	Tipleted cause of de	RI	AL	Print)	()	MU)	-	-100	OH	-6	
	Sta Registi		JAN 22 200	4	ing which	T. A	seed!							

			For State	State o	f Marylar	nd / Depa	artment rtificate			ind Me		giene Reg. No.	200	1.	01627
	Physici	an	1. Decedent's Name (First, Middle, ANNA FRAN		WIINS						2. Date of De. Month	ath Day	Ye		3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, PENINSULA REG	give street and nur		CENTE	4b. City, T	own, or I			1		County of E	eath	
	Funeral Director		217-14-8539	5. Sex 1 □ M 2 X2N F	7. Age (In yrs. 83	last birthday) Yrs.	If Under 1 Months	1 Year Days	If Under a	24 Hrs. (B. Date of Bird (Month, Da 09-12-	th 1920 -1920	9.	Birthpla Count Del	ace (State or Foreign ry) aware
	death with the Maryland ms 23s or 28s-f show f must be multiled at	tor	Usuel Residence of Decedent 10a. State 10b. County Delaware Sussex			ity, Town or Lo	ocation							10	od. Inside City Limits 1 ☐ Yes 2 🛣No
	h with the 3a or 28s	Dire	10e. Street and Number 9985 Middlefo				10f. Zip (_{Code} -9973	3			10g. Citi	zen of Wha US	t Count	ry?
036	s 1 and 2 should be filed within 72 hours after death with the Marylar f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23e or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie *XXWidowed 4 □ Divorced	12. Was Dece Armed Fo d 1 Tes If Yes, Giv Year or D	rces? 2 [XNo e		Was Decede If Yes, speci 1 Yes 2		panic Original Mexican Specify:	gin? (Spec , Puerto R	fy Yes or No ican, etc.)		14. Race - / Black, V Specify:	Vhite, e	itc.
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	ould be fited Mental Hygi harkad other hatic event, I	To Be C	17. Father's Name (First, Middle, L Norman James	ast)							(First, Middle, unknow		Sumame)		
Maryland	nd 2 shou alth and M 27 is mar ir traumat	-	19a. Informant's Name/Relationsh Gordon J. rawli								Route Numberd, DE			te, Zip (Code)
altimore,	do O		20a. Method of Disposition 1 ☒ Buriaf 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (Sp.	ecity)		Place of Dispo cemetery, crei dd Fell	matory or oti	her place	ery	Da 01 - 05			ford,		m, State
Balt	permit. Page Department important: If any injury o			anston	a the	I	P O Bo	on F x 96	uner 7. S	al Ho eafor	d. DE	1997	3		
	Physician /Medical Examiner		23a. Part . Enter the disease, or o shock, or heart failure. List of fmmediate Cause (Final disease or condition resulting in death)	a	aused the dea ach line.	ella					respiratory ai	4.5	VIG		Approximate interval Between Onset and Death
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ō	Phys this al di	atlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig.	28a. Date (<i>M</i> on	npatient 2 of Injury th, Day Year)	28b. Time o fniury		Bc. Injury Work	4 🗆 140	28	e 5 ☐ Resid 8d. Describe I			opecity)	
Division	o all de	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	286. Place	of Injury - At h ng, etc. <i>(Spec</i>	nome, farm, str	eet, factory,	, office		28	Bf. Location () City or Tox			r Rural	Route Number,
	the Hospital nin 24 hours a the Funeral I	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the xeminer: On the b and man	asis of examin ner stated.	ation and/or in	vestigation,	in my op	inion, dea	th occurre	d at the time,	date and	place, and	due to	the cause(s)
)	To the within 2 To the complet	ž	29b. Signature and title of certifier	K M	Lea	1	29c.	License	number	20%		29d. Dat	e signed (M	onth, D	o 4
I	SC		30. Name and address of person v	no completed caus	se of death (Ite	om 23a) (Type,	Print) 1/6//	51	·.	SAU	1564	N	mb	رد	1881
数	Sta Registi		31. Date filed (Month, Day, Year) JAN 05		agistrar's Sign	dature &	Spi	als							

Phys	ician	1. Decedent's Name (First, Middle, La			ificate of		2. Date of Death Month		3. Time of Death
	dical	GIRL KOZAL					January		
Exar	niner	4e. Facility Name (If not institution, give				Location of Death		4c. County of De	
- Funan	×	Greater Baltime 5. Social Security Number 6.5	Ore Medical (Sex 7. Age (In yrs. 1		If Under 1 Year	OWSON If Under 24 Hrs.	O Date of Dist	Baltir	
Funer Directo		NONE	1 □ M 2 🕅 F		Months Days	Hours Min.	8. Date of Birth (Month, Day, You January 4	9. E 2004	Birthplace (State or Fore Country) M D
and	di .	Usual Residence of Decedent 10a. State 10b. County	10c. Cih	, Town or Loca	ition		0		101 1 0
be filed within 72 hours after death with the Maryland lat hygiene. d other than "natural", or Itams 23s or 28s-f ehow event, the Medical Exama at must be notified at	Ď	MD		LTIMOF					10d. Inside City Lin 1 ☑ Yes 2 □
h the	Director	10e. Street and Number	N/A	וטוווטר	10f. Zip Code		10g.	Citizen of What	
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ler death w Itams 23a	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Wa		ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-	14. Race - Ar	nencan Indian,
within 72 hours after ban. than "natural", or Ita he Madical Exama	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		Yes 2XNo	Specify:	riloan, etc.)	Black, Wi	/
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2 a = 3		19a. Informant's Name/Relationship (19b. Mailing	Address (Street a	and Number or Rura	i Route Number, Ci	ty or Town, State,	Zip Code)
s 1 and 2 if Health a item 27 is other trau		20a. Method of Disposition					Towson		
of of H		1 Burial 2 Cremation 3	Removal from State Cro	ace of Dispositi	on (Name of fory or other place Cremato	9)		Location - City o	
permit. Pag Department Important: any injury o	_	 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer 	"					ltimore,	MD.
permit. Departmitimporta	ouce	21. Signature of Furieral Service aper	Med II	176	lame and Addres	s of Facility	\$5005 C	0. 7 111	
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death	. Do not enter t	the mode of dying	, such as cardiac o	r respiratory arrest,	· CIIII.	Approximate
Physicia	n	Immediate Cause (Final disease or condition							Interval Between Onset and Death
/Medica	af	resulting in death)	a. Severe P Due to (or as a consequ	remati ence of):	irity			-	-
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that the death cer ed by the attendin detached for use	icia	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea		topic pregnancy ther <i>(specify)</i>			Month	Day Year
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Physician: The law requires that the death certific this certificate has been signed by the attending praid indicator, page 2 should be detached for use as	by	Part II. Other significant conditions of	ontributing to death but not resul	ting in the unde	rlying cause giver	n in Part I.	23e. Did tobacc	o use contribute t	o the cause of death?
requi	ted						1 🗆 Yes	2 No 3 □ P	robably 4 Unkno
e law has b je 2 sl	npie.						24a. Was an autopsy	24b. Were a	utopsy findings availat
r: Th icate r. pag							performed?	death?	
siciar certif rector	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Death			
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To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)	/sician: To the best of my know iner: On the basis of examination and manner stated	ledge, death oc on and/or invest	curred at the time	, date and place, a nion, death occurre	nd due to the caused	s) and manner as	s steted.
o the	Mec	29b. Signature and title of certifier	and manner stated.		29c. License				
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			0 0 50	who	V	1611 2		-04-	21204
·B		30. Name and address of person who o	completed cause of death (Item 2	23a) / pe, Prin	t)				

			1 - For State Registrar	State of Marylan			f Health and of Death	Mental Hygie	- CUU4	01639
	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last Ann Johnson Rullma An Facility Name (If not institution, give	n		4b. City, Tow	n, or Location of De	2. Date of Death Month January ath	Day Yeer 7, 2004 4c. County of Deat	3. Time of Death 8:41 A
	Funeral Director	er	Anne Arundel Medic 5. Social Security Number 219-32-7975	al Center	last birthday) Yrs.	Annapo If Under 1 Y Months Da		s. 8. Date of Birth		del hplace (State or Foreign untry) yland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 33e or 28e-f show any injury or other traumatic event, II a Medical Evantment the rollined at once.	To Be Completed by Funeral Director	Usuel Residence of Decedent 10a. State 10b. County Maryland Anne Arun 10e. Street and Number 7 Bristol Circle 11. Marital Status 1 Never Married 2 Married 3X Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) James Brainard Joh 19a. Informant's Name/Relationship (T) Walter Rullman / S 20a. Method of Disposition 1 XBurial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Livens	del Anna 12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 V No If Yes, Give Year or Dates: cation e completed) College (1-4or 5+) TSOT Removal from State St.	16a. Deced (Give life. I Admin 19b. Mailir 3501A lace of Dispo emetery, crea Anne!	Ind. Zip Cod 21401 Was Decedent Yes, specify to In Yes, specif	of Hispanic Origin? Cuban, Mexican, Pur No Specify: coupation one during most of witired) Ve Assist 18. Mother's N Ruth El reat and Number or r place) ery 1/1 iddress of Facility J	(Specify Yes or No- rorking 16th ant Ir ame (First, Middle, Main izabeth Win Rural Route Number, Co. Pasadena Date 2/2004 Anr ohn M. Tayl	Citizen of What Co	10d. Inside City Limits 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
SOX 68760, ath certificate be executed The second of the second or use as the burial-transit or use as the second		Physician/Medical Examiner	If any, leading to introduction cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or as a consequence to (or as a consequence). Due to (or as a consequence). Due to (or as a consequence).	uence of): uence of): ncy death 3		1eum 6 v		23d. Date of deli	Approximate Interval Between Onset and Death Solution The solution of the so
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Division of Vital	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification: To Be (25. Was case referred to medical examiner? 1 Yes 2 70 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	lospital: 1 Mulatient 2 28a. Date of njury (Month, Day Yeer) 28a. Place of Injury - At hobiding, etc. (Specify	ER/Outpatien 28b. Time of Injury me, farm, str	28c. I	Other: 4 Nursing njury at Work? 1 Yes 2 No	eath (Check only one) Home 5 Residence 28d. Describe how in 28f. Location (Stree- City or Town, S.	njury occurred t and Number or Ru	
ฉั	To the Hospital or Atten within 24 hours after deat To the Funeral Diractor: completely filled in by the	Medical Cer	29a. Certifier 1 ertifying Phy	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death	29c. Lic	ense number	ce, and due to the causicurred at the time, date	e(s) and manner as and place, and due Date signed (Month	to the cause(s) , Day, Year)
1-14	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 9 201	/e Terson 32 registrar's Signal	MD	2001 A	Medical /MC	rarkway	ly Met	2146/

				State of M					Mental Hygic		01610
			1 - For State Registrar				rtificate of			U U 4 j. No.	0.640
	Dhusisi	,	1. Decedent's Name (First, Middle, I	Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		Roy C	lifford Rho	odes		·		January	9, 2004	1:50 A M
F	Examin	er	4a. Fecility Name (If not institution, g					r Location of Death		4c. County of Death	
			Anne Arundel			at hinth day	Annar		R Date of Birth	Anne Arun	
	Funeral Director		5. Social Security Number 6 225-54-8528	`	ge <i>(In yrs. I</i> a 53	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y March 26	ear) 9. Binn Cou	place (Stete or Foreign intry) 'qinia
pl.	ס		Usual Residence of Decedent						Taron 20	, 1, 5 10 VII	911114
	arylan show	_	10a. State 10b. County	- 22	10c. City,	Town or Lo					10d. Inside City Limits
	8a-1	Director		Arundel		Da	vidsonvil	rie			1 ☐ Yes 2XXXIo
	a or 2	급	10e. Street and Number				10f. Zip Code		100	. Citizen of What Cou	intry?
	ns 23	Funeral	1434 Governor B	Bridge Rd. 12. Was Decedent	t Ever in U.S	. 13.	Was Decedent of H		pecify Yes or No-	USA 14. Race - Amer	ican Indian.
0	r then	문	1 Never Married 2 Married	Armed Forces? d 1 ĎXYes 2 □	?		Was Decedent of H		Rican, etc.)	Black, White	, etc.
8	raf, o	5	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1958-	66	1 ☐ Yes ANO	Specify:		Specify: Wh	ite
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland and Menial Hyglene. marked other than "natural", or items 23a or 28a-f show maric event, the Medical Expraiser mail by molified at	Completed	15. Decedent's (Specify only highest of	Education grade completed)		(Give	dent's Usual Occup kind of work done	during most of work	king 16	b. Kind of Business/l	ndustry
12	within ne ne ne ne ne ne ne ne ne ne ne ne ne	du	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT use retire	d)		G t	
g 7	fited Hygie other	ပိ	12th 17. Father's Name (First, Middle, La	ast)		Mecn	anic	18. Mother's Nam	e (First, Middle, Ma	Securit	· <u>y</u>
an	id be ental ked c	To Be	Albert Leon	ard Rhodes				E	lizabeth (Gilliam	
ary	2 should and Men is marke sumatic	-	19a. Informant's Name/Relationship			19b. Maili	ng Address (Street	and Number or Ru	ral Route Number, C	City or Town, State, Zi	p Code)
	カモトラ		Joyce F. Rhodes	:/ Wife		143	4 Governo	r Bridge	Rd., Dav	idsonville	MD 21035
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 any injury or othar 2000.		20a. Method of Disposition 1 Burial 2 Cremation 3		COL	ce of Dispo	osition (Name of matory or other place			c. Location - City or T	
Ĕ	Pages Iment of lant: If its jury or o		*4 □ Donation 5 □ Other (Spe	ecify)			ematory	1–10	NAME OF TAXABLE PARTY.	Edgewater,	
3ai	permit. Departr Importa any inju		21. Signature of Funeral Service Lic	censee					_	alas Funer	
	40200		23a Part 1 Fotor the disease of or	omplications that cause	the death					gewater, M	D Z1037 Approximate
			23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	nly one cause on each I	line.	/	1	/		*	Interval Between Onset and Death
fi.	Physician /Medical		disease or condition resulting in death)	a Due to (or as	s a conseque	ance of):	Ung (ance	γ		10 months
ı.	Examiner			_							
	р #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	s a conseque	ence of):					
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.							
760,	te be executed ysician and e burial-transit	cal E		Due to (or as	s a conseque	ence or);					
687	eath certificate be executed attending physician and for use as the burial-transit			d							
ŏ	n centi nding use a	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Date of deliv	rery
m ·	death le atte	icla	in the past 12 months? 1 Yes 2 No	1 Live birth 4 Pregnant a			□Ectopic pregnancy □ Other (specify) _			Month	Day Year
o.	at the 1 by th stache	hys	9 🗆 Unknown	9□ Unknown							
	The law requires that the death certifica ste has been signed by the attending ph page 2 should be detached for use as th	by	Part II. Other significant conditions	s contributing to death t	but not result	ting in the u	inderlying cause giv	en in Part I.		co use contribute to	
Records,	w require been signature	Completed						<u></u>	1 DYes	2 No 3 Pro	bably 4 Unknown
Sec	has by	mple							24a. Was an autopsy performe	/ prior to co	opsy findings available ompletion of cause of
_			Or Man annual Manadian						1 Yes 2 €		2 □ No
Vita	Physician: The is this certificate ha ral director, page 2	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ient 2 T E	R/Outpatier	nt 3 DOA Oth	or.	th (Check only one)	e 6 □Other (Speci	6.)
0	g Phy er thi	n: T	27. Mannar of Death	28a. Date of Inju		28b. Time o	-		28d. Describe how		977
Ö	vttandin death. ctor: Aft y the fur	atlo	1 Accident 5 Pending investigat	ition	ay reary	injury		Yes 2□No			
Division of	or Atta	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	t be ed 28e. Place of In building, e	ijury - At hom tc. <i>(Specify)</i>	ne, farm, st	reet, factory, office		28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
	Hospital or Attanding Physician: 44 hours atter death: Furbaral Director Affer this certificately filled in by the funeral director,		200 Contilion 157 Contituing	Dh. i i i i i i i i i i i i i i i i i i i							
	Hos 24 ho Fun etely f	Medical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best xaminer: On the basis of and manner st	of examination	n and/or in	n occurred at the tir vestigation, in my o	ne, date and place, pinion, death occur	red at the time, date	se(s) and manner as a and place, and due to	stated. o the cause(s)
	To the Hospital or Attanding If within 24 hours after death. To the Funaral Director: After completely filled in by the funer	Me	29b. Signature and title of dentifier	1/. 1-			29c. Licens	e number	29d	. Date signed (Month),	Dey, Year)
)			> \(\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	10maloin		10	103	8445		1/9/	14
			30. Name and address of person wh	ho completed cause of	death (Item 2	23a) (Type.	Print)	1	^	11,11	1
			JAN VI	VEIDSIFIN	6	UC 1	Ddjety	MVE,	HAna	00/12, M	2
- Air	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 2	2004 32. Hargisti	rar's Signatu	M A	Gardo	/	/		

				State of Maryland				-	•	
			1 _ State	State of Maryland		rtificate of			eg. No. 2004	0 64
			Registrar 1. Decedent's Name (First, Middle, Last)			timouto or	<i>-</i>	2. Date of Dear	th	3. Time of Death
	Physici		Dora A	nnette	Ri	no		January	Day Year 2 2004	5:45 PM
	/Medic Examin	_	4a. Fecility Name (If not institution, give st		- 10-20	_	r Location of Deat		4c. County of Death	
	2.3.		8987 James Ring Ro			Westove			Somerset	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday). Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day,		nplece (State or Foreign untry)
	Director		219-36-5175 Usual Residence of Decedent	64				04/15/	1939 Mar	yland
	yland		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Ba-f	ctor	MD Somerset	We	stove					1 ☐ Yes 2 No
	vith th	Director	10e. Street and Number			10f, Zip Code	01071	1	Og. Citizen of What Co	untry?
	death with the Maryland ims 23s or 28s-f ehow r nust be notified at	eral	8987 James Ring R	oad 2. Was Decedent Ever in U.S	i. 13. V	Was Decedent of h	21871	Specify Yes or No-	USA 14. Race - Amer	ican Indian,
(0	r Itan	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No	ĺ	1.4		specify Yes or No- to Rican, etc.)	Black, White	, etc.
Ö	72 hours after natural', or Ita	1 by	3/⊠ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1□Yes 2∰(No	Specify:		Specify: Wh	ite
5	72 h	Completed by Funeral	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	rking	16b. Kind of Business/I	ndustry
12	within ene. than "	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		vner/Oper			Farm	
d 2	filed Hygi other ent,	C	17. Father's Name (First, Middle, Last)		OV	viier/oper		me (First, Middle, I		
Maryland 21215-0036	fental fental rked c	To Be	Paul Mitchell Davi	s			Ella B	eatrice .	Johnson	
lary	2 should be and Mental le marked (19a. Informant's Name/Relationship (Typ						City or Town, State, Z	
	and seelth m 27		Karon Bowden/Daugh			Sharon sition (Name of	Drive, P		Anne, MD 21	
ŏ	Peges 1 nent of H int: If Ite iry or ot		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re	moval from State	metery, crer	natory or other pla				
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Menial Hygiene. Important: if Item 27 le marked other than "natural; or Itams 23e or 28e-f ehow any Injury or other traumatic event, the Marical Extrinitier in Lat be notified at once.		* 4 □Donation 5 □Other (Specify) Property Signature of Funeral States Price Livense			d Cemeter Name and Addre		6/2004	Princess An	ne, MD
Ba	permit. Departm Departm Importa- eny Inju	(June K NIAI	7/4	H:	inman Fur	ieral Hom		ess Anne, M	m 21853
N	TEU :		a. Pert1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death.	Do not ent	er the mode of dyi	ng, such as cardia	c or respiratory arr	est,	Approximate Interval Between
J	Pnysiclan	. 7	mmediate Cause (Final disease or condition	mol	mate	ter Lu	ma Con	er to	Brain	Onset and Death
r	/Medical Examiner	Ĭ	resulting in death)	Due to (or as a conseque	ence of):		0			
	Examilier	<u></u>	Saluentially list conditions if any, leading to immediate	Due to (or as a conseque	ence on:		505		-	
_	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	500 (0) 45 4 5010040.	ones 517.					
Ć,	te be executed ysicien and te burial-transit	Exa	that initiated events c. resulting in death) Last	Due to (or as a conseque	ence of):					
3760,	ate be nysicie he bui	ical	d.							
k 68	death certificate t e attending physion of for use as the to	Physician/Medi	IF FEMALE:							570.5
Вох	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	 c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of deal 	death 3	Ectopic pregnanc Other (specify)	у		23d. Date of deliment	very Day Year
P.O.	the characters and the characters are the characters and the characters are the character	iysic	1 Yes 2 No 9 Unknown	9□ Unknown	am J_	JOHNEI (Specify)				
	s that the ned by detact	by Ph	Part II. Dther significant conditions cont	ributing to death but not resul	ting in the u	nderlying cause gr	ven in Part I.	23e. Did tol	pacco use contribute to	the cause of death?
rds	The law requires that ite has been signed b page 2 should be deta	ed b							as 2 No 3 Pro	bably 4 Unknown
ဝ၁	e lawre has bee je 2 sho	Completed						24a. Was a autops		opsy findings available ompletion of cause of
Œ.		Com						perform	ned? death?	2 No
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	and the latest and th				ath (Check only on	ө)	
of \	Physician: this certificantal director.	- To	1 ☐ Yes ZNo	ospital: 1 Inpatient 2 E 28a. Date of Injury	R/Outpatier	I 3 DOA			ence 6 Other (Spec	ıfy)
ou	ding I h. After funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wo	rk?]Yes 2∐No	200, 20001100 110	ow injury occurred	
Division of Vital Records,	l or Attending after death. Diractor: After I in by the fune	ifica	3 Suicide 6 Could not be	28e. Place of Injury - At hor	ne, farm, str	eet, factory, office		28f. Location (St City or Town	reet and Number or Ru	ral Route Number,
Ö	s afte s afte el Dira ed in l	Certification:	4 Hollicide	building, etc. (Specify)				City of Your	i, State)	
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical Examin	cian: To the best of my knower: On the basis of examination						
	the thin 2 the mplet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens	se number	2	9d. Date signed (Month	, Day, Year)
	7 × × 8		11.QA	A			66576		1/6/04	
			30. Name and address of person who cop	npleted cause of death (Item	23а) (Туре,	Print)	_		0 4	
_			Ronald P-		560	Dur	iale D	rue E	saluly	10812 DM
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signatu		1			9	
- 30	negisi	11.	UMIN U (LUUY F KANAGUKE	13	Little Alle				

			For State Registrar	State of	Maryland	d / Depa <i>Cer</i>	artmen <i>tificat</i>	t of Hea e <i>of De</i>	alth and Meath	dental Hyg	giene 2 Reg. No.	00	+ 01642
			1. Decedent's Name (First, Middle, La	ist)						2. Date of Dea	ath Day	Year	3. Time of Death
	Physicia		James Hollister	Roberto	n					Januar		2004	11:08A M
	/Medic Examin		4a. Facility Name (If not institution, given				4b. City,	Town, or Lo	cation of Death			inty of Dee	th
		•	4610 Chevy Chas	e Boulev	ard		Che	vy Cha	ise		Moi	ntgom	ery
	Funeral		5. Social Security Number 6. S	Sex	7. Age (In yrs. I	ast birthday)	If Under Months		Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h v. Year)	9. Bir	thplace (State or Foreign ountry)
	Director		342-20-6594	1 XM 2□F	95	Yrs.	Wioritis	Days	Nun.	Dec. 20	, 1908	B Mi	nnésota
	2		Usual Residence of Decedent		10- 01-	. T							10d. Inside City Limits
	try lar	_	10a. State 10b. County			, Town or Lo							1 ☐ Yes 2 ☑ No
	Ba-f-	ct	Maryland Montgom	ery	Che	vy Cha	_						
	or 2	Directo	10e. Street and Number				10f. Zip				10g. Citizen		•
	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or itema 23a or 28a-f ahow avent, the Medical Examiner must be notified at		4610 Chevy Chase					0815			United		
	r de	Funerai	11. Marital Status	Armed For		S. 13. \	Was Deced fYes, spec	lent of Hispa ify Cuban, N	anic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)	14.	Black, Whi	erican Indian, te, etc.
ð	or li	by Fi	1 Never Married 2 Married	1 (X) Yes If Yes, Giv	² □No Wor	ld .	1 🗆 Yes	2 ∑ No S	Specify:		Spe	ecify:	
9500-91212	ural'		3 ☑ Widowed 4 □ Divorced	Year or Da	ates: War		dont's Haus	1 Occupation			16b. Kind o	Wh:	
Ÿ	"nat	Completed	15. Decedent's E (Specify only highest gr	ade completed)		(Give	kind of wo	Il Occupation rk done durit se retired)	ng most of work	king			ntelligence
2	within 72 ene. then "net the Wedler	g	Elementary/Secondary (0-12)	College (1	-4or 5+)			s Offi	icer		oene.	Age	_
	Hygie The nt.	e Co	17, Father's Name (First, Middle, Las.			орста	461011			e (First, Middle,	Maiden Sun		псу
	ntal ed o	8	James Gilmore Ro	_					Antoine	ette Lew	ri e		
Ē	should be nd Menta marked imatic av	5	19a. Informant's Name/Relationship			19b Mailin	na Address	(Street and		al Route Number		wn. State.	Zip Code) 2000 C
<u>s</u>	d 2 s th an 7 la		James C. Roberto				•						20886 lage, MD
o,	1 an Heal em 2 em 2		20a. Method of Disposition	11/ 5011	20b. P	ace of Dispo	sition (Nar	ne of		Date	~ .		Town, State
وّ	ages in a lit		1 ☐ Burial 2 ☐ Cremation 3	☐Removal from S	State	emetery, cren			Janua 2004	ary 9,	Duchf.	- A	Minnagata
Baltimore,	Tan Tan Tan		* 4 □ Donation 5 □ Other (Special Service Light)		Uar	Grove							Minnesota ineral Home/
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic avones.		21. Signature Puried Service Light	e mad	мос	I R	ethes	da-Che	evy Chas aryland	se, Inc.	7557 3501	Wisc	onsin Avenue
ш	1.14		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that co	aused the death								Approximate Interval Between
8	Physician		Immediate Cause (Final	Uren									Onset and Death
	/Medical		disease or condition resulting in death)	d	or as a consequ	uence of):							
	Examiner			Chro	onic Rer	nal Fa:	ilure						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		or as a consequ								
	cuted nd ransil	Examiner	Cause (Disease or injury that initiated events	c. Obst	ructive	Uropa	athy						
ó	be executed sician and burial-transit	EX	resulting in death) Last	Due to (or as a consequ	uence of):							
8760	icate be executed physician and s the burial-transit	dicai	,	_d Neph	rolithi	lasis							
9		- w	IF FEMALE:										
Box	eath certifi attending p	lan/	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Fetal	death 3	Ectopic p				23d.	Date of de Month	livery Day Year
o.	e de the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregn 9☐ Unkno	ant at time of de own	eatn 5∟	Other (sp	өспу)					
<u>.</u>	that the de ned by the a detached t	Physician/M	Part II. Other significant conditions	contributing to de	eath but not resu	ulting in the u	nderlyina d	ause given i	n Part I	23e Did to	obacco use o	contribute to	o the cause of death?
Records,	50 00	l by	Advanced Malnutr				,	g		101	res 21X N	o 3□P	robably 4 Unknown
Ö	w require been signalould b	Completed		-						242 1450	 	th Word a	utongu findinge available
Şec 2	sician: The law certificate has b irector, page 2 s	d L	Congestive Heart	Fallure	2					24a. Was autop	an 24 rmed?	prior to death?	utopsy findings available completion of cause of
<u> </u>	cate h		Metastatic Prost	ate Caro	cinoma_					1 ☐ Yes	2 X No	1 🗌 Yes	s 2 No
Viital	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Othors		th (Check only o			
ō	this ald	2	1 ☐ Yes 2 No 27. Manner of Death		npatient 2	28b. Time of		/A		ome 5 Tesion 128d. Describe I			ecify)
5	ing After une	lo.	1 ⊠Natural 5 ☐ Pending		of Injury th, Day Year)	Injury	м	8c. Injury at Work?	2 □ No	200. 0000.00			
200	eat or:	Icat	2 Accident investigate 3 Suicide 6 Could not		of Injury - At ho	me farm etr				28f. Location /5	Street and Ni	umber or R	ural Route Number,
Division	If or Attend after death Diractor: ,	Certification:	4 ☐ Homicide determined	buildii	of Injury - At ho ng, etc. (Specif)	<i>()</i>	991, 140101	, onlos		City or Tov	vn, State)		
	To the Hospital or Att within 24 hours after d To the Funeral Diract completely filled in by	edical C	29a. Certifier 1										
	To the within To the comple	Me	29b. Signature and title Certifier	1			29	c. License no	umber		29d. Date si	gned (Mon	th, Day, Year)
	1		1					D47867	7		Januai	cy 5.	2004
	3041		30. Name and address of person who	completed caus	e of death (Item	23a) (Type,						<i>y</i> ,	
			Oney Zuniga, M.D	4701	Randol	oh Roa	d, #1	01, Ro	ockville	e, Maryl	and	20852	- 2257
	Sta	ate	31. Date filed (Month, Day, Year)	32. R	egistrar's Signa	ture /	h	acks	1				
	Regist	rar	JAN 0 6 2	<u>/</u> UU4 /	Leper	~	17						

			For State Registrar	State o	f Marylar				ealth a Death		ental Hy	giene Rag. No.	21101	+ 0	16	43
	Dharini		1. Decedent's Name (First, Middle,	Last)							2. Date of Dea	ath Day	Yea		ne of D	
н	Physici Medic/		Margaret Mary 1								January		2004	3:3	10	A. ^M
п	Examin	er	4a. Fecility Name (If not institution,		nber)				Location o	of Death			County of De			
			Sacred Heart H	ome 6. Sex	7. Age (In yrs.	last birthday)		r 1 Year	ville If Under	24 Hrs.	8. Date of Birt	h	ince C			Foreign
	Funeral Director		577-01-0717	1□M 20XF	97	Yrs.	Months	Days	Hours	Min.	(Month, Da Feb. 22	y, Year)		irthplece (St Country) ennsy1		
	D		Usual Residence of Decedent			÷										
	show	٦	10a. State 10b. County			ty, Town or Lo								10d. Insi		2 □ No
	the M	Director	Md. Prince	George's	1	Hyattsv		p Code	-			10a. Citi	zen of What	21		
	with with		5805 Queens C	hanol Por	ı d			•	782				U.S.A			
	death	Funeral	11. Marital Status	12. Was Deci	edent Ever in U	J.S. 13.	Was Dece			gin? (Spe	cify Yes or No- Rican, etc.)	-	14. Race - Ar	nericen India	ın,	
တ	or ite		1 Never Married 2 Marrie	Armed For 1 Tes If Yes, Gir	2 No	1	ii res, spi 1 □ Yes		Specify:		rican, etc.)		Black, Wi	lite, etc.		
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Baltimore,	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service L		1/		2. Name a		s of Facilit	ty		PIT	ver Sp	ring,	Md.	
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Вох	death atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 XNo		irth 2 ☐ Feta nant at time of c		Ectopic p Other (s	pecify)					Month	Day	Ye	ar
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=	ysicia is cert directo	To Be	examiner? 1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 🗆 🗅	OA Othe			<i>(Check only o</i> ne 5 ☐ Resid		3 ∏Other (St	ecify)		
0	ding Phys h. After this funeral di		27. Manner of Death	28a. Date		28b. Time o		28c. Injury Work			28d. Describe h			,,		
Sio	Mtendin death. ctor: Af y the fur	atic	1 XNatural 5 Pending 2 Accident investig	ation		,,,,	М		Yes 2 🔲	No						
Division of Vital Records,	or Attending Physician: uter death. Director: After this certific in by the funeral director,	ertification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		iome, farm, sti fy)	reet, facto	ry, office		2	28f. Location (5 City or Tox			Rural Route	Numbe	эг,	
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	O	29a. Certifier 1 🖸 Certifying	Physician: To the	hest of my kn	owledge deat	h occurre	d at the tim	ne date an	nd place a	and due to the	cause(s)	and manner	as stated		
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	within To th	Me	29b. Signature and title of certifier										nth, Day, Ye	ar)		
¢	L) DAN	51520 January 6,								ary 6.	2004			
•	7		30. Name and address of person v													
			Bahram Pishdad 31. Date filed (Month, Day, Year)		328 Sot legistrar's Sign		Ave.	S.E.	. #310	0Wa	shingt	on,	D.C.	20032		
	Sta Registi		-IAN 0 7		agistrar's Sign	G	10	acks	/							

			For		Maryla	nd / De	partme	nt of H	ealth a		ental Hy	giene	200		-11
			1 - State Registrar	<u> </u>			ertifica	te of L	Death			Reg. No.	200	4 011	144
	Physicia	an	1. Decedent's Name (First, Middle, Las	-		D 1 1 0 2					2. Date of Dea Month	Day		3. Time of 0	
	/Medic		Rozelyn			Riley					anuary		2004	6:17	A. M
	Examin	er	4a. Facility Name (If not institution, give	street and num	ber)			, Town, or Bethe	Location o	of Death			County of De		
Н			5702 Maiden Lane 5. Social Security Number 6. Se		7. Age (In yrs	last hirthd		or 1 Year	If Under 2	24 Hrs.	8 Date of Birt		Montgo		Foreign
	Funeral			M 2180]F /	91		Months		Hours	Min.	8. Date of Birt (Month, Day Feb. 21	Year)	12	lirthplace (State or Country) Georgia	roraign
	Director		Usual Residence of Decedent									,		7018-4	
	yland Now		10a. State 10b. County		10c. C	ity, Town o	r Location		_					10d. Inside City	
	Mar	to	Maryland Montgome	ry			Bethe	sda						1 🗆 Yes	2X No
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	tanga de	Jue	11. Marital Status	12. Was Deced	ces?	J.S. 1	Was Dec If Yes, sp	edent of Hi ecify Cuba	ispanic Orig n, Mexican	gin? (Spec i, Puerto R	cify Yes or No- tican, etc.)		14. Race - Ar Black, W	nerican Indian, hite, etc.	
S	s afte	by Fi	1 ☐ Never Married 2 ☐ Marned 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Give Year or Da	-		1 🗆 Yes	2⊠ No	Specity:				Specify:	White	
3	hour tural	q pe	15. Decedent's Ed		105.	16a. De	cedent's Us	ual Occupa	ation			16b. Ki	nd of Busine	ss/Industry	
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yland	Abnta Abnta rked rked	To E	Robert E. Falliga	ınt					Joha	ınna (Corinne	Ba	iley		
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or itams 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		19a. Informant's Name/Relationship (7				-				Route Numbe				
Σ.	and salth		Susan A. Riley/Da	ughter	1				ne, B		sda, Ma			0817	
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Ē	Pag ment ment iury		* 4 ☐ Donation 5 ☐ Other (Specify)			n Ceme			2004				Maryland	
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	007 e d		Kajon)198	557 Wi	scons	in Av	e., B	ethesd	a, M	2081	4-3501 Approximate	
) 21		23a. Part 1. Enter the disease, or composhock, or heart failure. List only of	one cause on ea	ich line.	ith. Do not	enter the m	oae or ayını	g, such as	cardiac or	respiratory ar	rest,		Interval Betw Onset and D	/een
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Advan			e Deme	entia						01d	
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00,	leath certificate be executed attending physicien and I for use as the burial-transit	cal	· ·	d											
0	tificat ig ph) as th														
Š	h cer endin	N/us	23b. was decedent pregnant	23c. If yes, outc	ome of pregr		3 □Ectopic	pregnancy				2	23d. Date of o		
	deat ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No		ant at time of		5 Other (Month	Day Y	ear
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ń	res th igned be d	by	Part II. Other significant conditions co	onthouting to dea	ath but not re	suiting in th	e underlying	cause give	en in Part I.			es 2[to the cause of de Probably 4 Uli	
cords,	een s een s	Completed									-				
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5	Phys rthis raldi	. To	1 X Yes 2 No 27. Manner of Death	28a. Date o	f Injury	28b. Time	tient 3□ (e of	28c. Injury	/ at		e 5 Resid			эвсігу)	
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22	Attendii r death. ector: A by the fu	ifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place	of Injury - At I		street, fact	ory, office		28	Bf. Location (S City or Tow	Street en	d Number or	Rural Route Numb	9 0 7,
5	al or	Certification:	4 D Nomicide	Dullan	g, etc. (Spec	(i y)					Only of 100	m, State,	,		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	cal (29a. Certifier 1⊠ Certifying Phy (Check only 2 Medical Exam	ysician: To the	best of my kn	owledge, d	eath occurre	d at the tim	ne, date and	d place, ar	nd due to the o	ause(s)	and manner	as stated.	
	the H nin 24 the F nplete	ledical	one)	and mann											
	To So Tile	Σ	29b. Signature and title of certifier	1	10.	non	2	9c. License			'			nth, Dey, Year)	
	<		A. all &	201	11/	11		D31	.319			Jan	uary 6	, 2004	
	9		30. Name and address of person who d					T)	1 ¹	1_ 34	1	1 00	01/		
	Sta	to	Loreto Albiol, M.I 31. Date filed (Month, Day, Year)	32. R	gistrar's Sign	nature /	Avenu	e, Be	cnesd	ıa, M	aryland	1 208	814		
	Sta Registr		JAN 09 20		eneva		P	onk	San San San San San San San San San San						

State of Maryland / Department of Health and Mental Hygiene ? 1 1 1 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** JAN. VINCENT JOSEPH RYBA, JR. 2004 9:15 p^M /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner GAITHERSBURG MONTGOMERY WILSON HEALTH CARE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Dey, JULY 9 Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 F 74 1929 ΝY 103-24-3639 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County be filed within 72 hours after death with the Marylan tal Hygiene.

and Hygiene.

and other than "naturel," or freme 23a or 28a-f show event, its Madical Exprise multile and event, its Madical Exprise multile. or 28a-f show 1 Yes 2 No MONTGOMERY MD GERMANTOWN Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 18501 KINGSHILL ROAD 20874 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MATHEMATICIAN RESEARCH & DEVELOP. 5+ 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fit Department of Health and Mental H Important: if I tem 27 is marked oth any injury or other traumatic even 900.6: Be CASMIRA KIEDROWSKI VINCENT RYBA 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ANN SNYDER / DAUGHTER 107 BOOKHAM LA., GAITHERSBURG, MD 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ST. MARY'S CEMET. 1/22/04 BARNESVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PARKINSON'S PISEASE Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner S. uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year ŏ in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 X No 3 Probably 4 □Unknown 1 ☐ Yes 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 1 Yes 2 No Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No in by the funeral dir 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Accident 1 ☐ Yes 2 ☐ No death. after death 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) filled 24 hours a 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and doe to the dads(s) and manual and all the cause (s) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 ho To the Func completely f 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature JANUARY 19, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHAPLES M. SEND (0.8)

31. Date filed (Month, Pay, 19ar) 2004 32. Jegistrar's Signature. 10801 LOCKWOOD DRIVE \$205, SILVERSPLING State Registrar

				1 - For State Registrar	State of M	larylan		artment o			d Mental H	lygien Reg. N	60	04	0 6	546
				1. Decedent's Name (First, Middle, L	ast)						2. Date of Month	Death Da	av	Year	3. Time of I	Death
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				The Memoria					25 to					ubc	•	
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		pu .		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10	0d. Inside Cit	v Limits
		r death with the Maryland tems 23e or 28e-f show er must be notified at	5				•								1 ₽ Yes	
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		ns 23a	Funeral	826 Robbin Str	12. Was Deceder	nt Ever in U.	.S. 13. V		L613 nt of His		(Specify Yes or Jerto Rican, etc.)			- Americ	an Indian,	
>	-10	L S M	Ξ	1 Never Married 2 Married	Armed Forces	s?					ierto Rican, etc.)			c, White,	etc.	
6	036	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	i;	'	1 ☐ Yes 2 ☑	No	Specify:			Specify:	Bla	ck	
V	5	72 hours after natural', or its dicul Examina	ted	15. Decedent's (Specify only highest g	Education		(Give	dent's Usual C	done du	ion iring most of	workina	16b. I	Kind of Bus	siness/Inc	lustry	
Stan	21215-003	ithin	Completed	Elementary/Secondary (0-12)	College (1-40	r 5+)		DO NOT use								
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1	ng	be fi	Be									-111		9/		
,)	Ĕ	d Mei nark natic	2	John R. Stanl 19a. Informant's Name/Relationship	-		19b Mailin	an Address /S			Margret Rural Route Nu			State Zin	Code)	
E	Maryland	permit. Peges 1 and 2 should be filed within 72 hours afte Department of Heath and Mental Hygiene. Important: if Item 27 ie marked other than "natural", or it any fojury or other traumatic event, the Medical Exariat any		Brenda Stanley			1				Cambrid					
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				23a. Party. Enter the disease, or co sheck, or heart failure. List on	mplications that ceus y one cause on each	ed the deat	h. Do not ente	er the mode o	of dying,	such as care	diac or respirator	y arrest,			Approximate Interval Betw	veen
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	68	tificat ig ph) as th														
	Box	feath certificate to attending physical I for use as the b	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic preq	nancy				23d. Date		*	'ear
	Э. В	o death	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4∏Pregnant 9□ Unknown	at time of d		Other (spec				-	Mon	ξΠ	Day Y	Ball .
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	Z.	ysician: is certific director.	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	tiont 2	ER/Outpatien	* 3 T DOA	Other	-	Death (Check or g Home 5 ☐ R	1	6 MOthe	r (Specific		
	of	g Phy er this eral d	n: To	27. Manner of Death	28a. Date of Ir (Month, L		28b. Time of		: Injury : Work?		28d. Descri				/	
	ion	tending Ph leath. tor: After th the funeral	atio	1 Natural 5 Pending 2 Accident investigat		Jay 1991)	Injury	М		es 2 No						
	Division of Vital Records,	To the Hospitel or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	289. Place of	Injury - At hi etc. (Specif	ome, farm, str (y)	eet, factory, o	office			n (Street a Town, Stai		r or Rura.	Route Numb	ber,
		pitel ours a eral E		29a. Certifier X Certifying	Physician: To the be	st of my ken	wieden desti	h occurred at	the time	a date and of	ace, and due to	he causel	s) and man	mar as et	ated.	
		24 hc 24 hc 8 Fun etely 1	edical	(Check only 2 Medical Ex	aminer: On the basis and manner	of examina	ition and/or in	vestigation, in	my opi	nion, death o	ccurred at the tir	ne, date ar	nd place, a	nd due to	the cause(s))
		ro the	Me	29b. Signature and title of certifier				29c. L	License	number		1	ate signed		Day, Year)	
		F > F 0		D				D	00	5706	7	0	1/05/	104		
	•			30. Name and address of person wh	o completed cause o	f death (Item	п 23а) (Туре,	Print)					. 6			
				DAMIAN SOOK				ran's	LA	NE,	EASTO	~ N	עד	2160	/د	
			ate	31. Date filed (Month, Day, Year)	32. Regis	strar's Signa	ature									

			1 - For State Registrar	State of Marylar		artment rtificate			and M		Reg. No.	2004	01647
186°.	Physica /Media		Decedent's Name (First, Middle, Last) PAULINE WRIGHT YO							2. Date of De Month JANUARY	Day	2004	3. Time of Death 6:30AM M
	Examir		4a. Facility Name (If not institution, give s HEARTFIELDS	street and number)		4b. City, 1 EAS		Location of	of Death		4c. Co	unty of Death	
8	Funeral Director		214-40-4404	7. Age (In yrs. 92	last birthday) Yrs.	If Under Months		If Under: Hours	Min.	8. Date of Bird (Month, Da AUG 11	y, Year)	9. Birthe Coul MARYI	
	the Maryland 28a-f ehow	or	Usual Residence of Decedent 10a. State 10b. County		y, Town or Lo							1	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the N or 28a-f	Director	MD TALBOT		ROYA	AL OAK	Code				10g. Citizen	of What Cour	
336	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f ehow imatic event. If a Medical Examination in colling at	by Funeral	25619 MOORES RD 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 (X)No If Yes, Give Year or Dates:					gin? (Spe , Puerto F	cify Yes or No Rican, etc.)	1	USA Race - Americ Black, White,	
215-0036	ithin 72 hou na. "natura nan "natura n Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation com <i>pleted)</i> College (1-4or 5+)	16a. Dece (Give life.	dent's Usual kind of work DO NOT use	l Occupa k done d e retired,	ntion luring most	t of workir	ng	16b. Kind o	of Business/In	
nd 2	be filed tal Hygi d other	Be	12 17. Father's Name (First, Middle, Last)	4	<u></u>	CEACHE	ER			(First, Middle,			DUCATION
Mary	is 1 and 2 should of Health and Men item 27 is marke other traumatic	2	JAMES BLAINE WRIGH 19a. Informant's Name/Relationship (Type RICHARD L. COUNTS	oe, Print)		ng Address		nd Numbe	r or Rura	BELL Route Numbe		wn, State, Zip	Code)
a)	0 0 - 1-		20a. Method of Disposition 1 Burial 2 Gremation 3 Re 4 Donation 5 Other (Specify)	emoval from State	Place of Dispo emetery, crer	sition (Name	e of her place	9)	D	ate L-7-200	20c. Locati	on - City or To	
Balti	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service License	-	7 FF	Name and	Addres	s of Facility	BETN	& NEWN	AM FIII	JERAT. H	
- 8	hysician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each line.	h. Do not ent	er the mode	of dying	g, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions.	Due to (or as a conseq	uence of):				22.047				Syan y
8/60,	certificate be executed nding physician and use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)									
ň	death e atter	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ac. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do	death 3	Ectopic pre					23d.	Date of delive Month	ry Day Year
ecords, P.	law requires that the de as been signed by the a 2 should be detached t	Ď	Part II. Other significant conditions cont	tributing to death but not resi	ulting in the ur	nderlying car	use give	n in Part I.			bacco use c		e cause of death?
r	The te h	Completed								24a. Was autop perfor 1 Yes	med?	death?	osy findings available noletion of cause of
	ng Phy fter this Ineral d	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Ho 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 Inpati	ER/Outpatien 28b. Time of Injury		c. Injury Work	r: 4 🗆 Nur	rsing Hom	(Check only or le 5 ☐ Resid 8d. Describe h	ence 6X		ASSISTED LIVING
DIVISION	tal or Attendi is after death. al Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, stre	eet, factory,	office		21	8f. Location (S City or Tow	treet and Nu n, State)	m <i>ber</i> o <i>r Rur</i> ai	Route Number,
;	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	one) 2 Medical Examin	ician: To the best of my knoter: On the basis of examinal and manner stated.	wledge, death tion and/or inv	estigation, i	n my op	inion, death	f place, ar h occurre	d at the time, o	late and plac	e, and due to	the cause(s)
	viti To	2	29b. Signature and title of certifier	3 Chilas	10	12	License	number	66	2	29d. Date sig	ned (Month, E	Day, Year)
	â		30. Name and address of person who cor LUDWIG J EGLSEDE 31. Date filed (Month Day, Year)	D TTT W D	0.C D.T.	,	S LA	NE EA	ASTON	, MD 2	1601	and the second	
- 1 25	Sta Registr		JAN 06 200	R, III M.D. 6	Los	de							

DAP State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Howard William Siebecker JANUARY 6,2004 2:15 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 59 BARRETT ROAD CONOWINGO CECIL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, April 13, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 227-06-8799 35 Pennsylvania Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show r then "natural", or iteme 23s or 28s-f ehov the Medical Examiner must be posified as 1 ☐ Yes 2 No Director Cecil Conowingo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21918 59 Barrett Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Bayer Pharmaceutical Company Il Hygiene. College (1-4or 5+) Two Years Elementary/Secondary (0-12) Bio Medical Engineer Baltimore, Maryland Pages 1 and 2 should be filed w thent of Health and Mental Hygien tant: if Item 27 is marked other ti jury or other traumatic event, III. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Lewis Siebecker Margaret Mackrel 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Siebecker (wife) 59 Barrett Road, Conowingo, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of I important: If ite eny injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 01/11/04 R.A. Ferris & Co., Inc. 4 Donation 5 Other (Specify) West Chester, Pennsylvania permit. Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 21. Signature of Funeral Service Licensi Thomas IN. ATTERDEN, ST 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cu /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical IF FEMALE 950 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day 5 Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 🔼 nknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page IPTes 2□No To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{XOther} \) Other (Specify) \(\text{SCENE} \) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA YXYes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending lefe of stuffe 1 Yes 2 No 0157 HRJ within 24 hours after death. To the Funeral Director: A 2 Accident investigation V(6(04 the 6 Could not be determined St. Location (Street and Number or Rura Route Number, City or Town, State) Sureide 4 Homicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) in by t 9 Ba ett live home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the buse(s) and manner as stated. 10, pellil Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JANUARY 6,2004 **OCME** ode 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 111 Penn Street, Baltimore, Maryland 21201 MENDORE MILLY 31. Date filed (Month, Day, Year) Registrar's Signature State JAN 0 8 2004 Registrar

		ı	1- State of M	aryland /		rtment of h			giene 200	4 01649
			Decedent's Name (First, Middle, Last)					2. Date of De	ath	3. Time of Death
	Physici		AILEEN SARMA	ST				January	Day Yea 8 2004	4:00 p. ^M
į.	/Medic Examin		4a. Facility Name (If not institution, give street and number)			4b. City, Town, o	or Location of Dea		4c. County of De	
	LAGIIIII	CI	Anne Arundel Medical Cente	ar		Annanol	ic		Anne A	runde!
	Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last b		Annapol If Under Year Months Days				irthplace (State or Foreign Country)
	Director		212 - 08-4436 1□M 2∏F	35	Yrs.	Mortus Days	HOUIS MIII			ashington, DC
	р. "		Usual Residence of Decedent	10c. City, Tox		atio -				10d. Inside City Limits
	aryla shov	<u>.</u>	10a. State 10b. County	Steve						1 Yes 2 No
	8e-f	ctc	Maryland Queen Annes	steve	EIISVI					
	vith ti	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	•
	be filed within 72 hours after death with the Maryland ital Hyglene. did Hyglene. did other than "neturel", or items 23a or 28e-f show event, I're Medical Exatt er minal be notified at	Funeral	612 Old Love Point Road 11 Marital Status 12. Was Decedent	Fires in II C	12 14	21666	liannois Osigina /6		United Stat	Ces nerican Indian.
	er de Item	ŭ,	11. Marital Status 12. Was Decedent Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 23€	•	IS. VV	Yes, specify Cub	lispanic Origin? (S an, Mexican, Puer	to Rican, etc.)	Black, W	
8	rs aff	by F	3 ☐ Widowed 4 ☑ Divorced Year or Dates:	No	11	Yes ⊉∏ No	Specify:		Specify: \[Vhite
215-0036	ture sture	ed	15. Decedent's Education	16	a. Decede	nt's Usual Occup	pation		16b. Kind of Busines	s/Industry
212	within 72 ene. than "ne!	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or:	5.1)	(Give k. lite. Di	ind of work done O NOT use retire	during most of wo d)	rking		
_	r tha	E	12		Messa	ge Thera	apist		Private	
	Hygie other	BeC	17. Father's Name (First, Middle, Last)				T	me (First, Middle	, Maiden Sumame)	
<u>a</u>	should be ind Mental marked o umatic eve	To B	Victor Sarmast				Adrienr	ne Wiltz		
Maryland	s 1 and 2 should if Health and Men item 27 is marke other treumatic		19a. Informant's Name/Relationship (Type, Print)		-				er, City or Town, State	
	1 and 2 Health a Iem 27 is		Adrienne Rogers (Mother)		407 N	. Main	Street E	Edinburg	, Virginia	22824
altimore,	es 1 au of Hea of Hea fitem rothe		20a. Method of Disposition	20b. Place cemet	of Disposi	ition (Name of atory or other pla	ce) Jani	Date nary 14,	20c. Location - City	or Town, State
Ē	permit. Pages Department of Importent: If it any injury or o		1 ☐ Burial 25☐ Cremation 3 ☐ Removal from State • 4 ☐ Donation 5 ☐ Other (Specify)	Chesa	apeak Cent	e Cremat	tion 20	004	Chester, N	laryland
Ħ	mit. partm porte		21. Signatura of Fine al Service Licensee						eral & Memo	orial Care
ñ	Depa Impo any i) Drawn	100982	_				is, Marylan	
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li	d the death. Do		-				Approximate Interval Between
	Pnysician	o n	Immediate Cause /Final			2		. 41.	C 2 4 6 . 3	Onset and Death
	/Medical			a consequence		1170	UMOULU	vira	sepsis) Thays
П	Examiner									
	_	ē	Sequentially list conditions, if any, leading to immediate Due to (or as	a consequence	e of):					
	uted	Examin	Cause (Disease or injury that initiated events c.							G.
o	te be executed ysician and ie burial-transit			a consequence	e of):					
1760,	w ~ w	cai	d							-
89	leath certifical attending phy I for use as th	Jed	IS SERVALE.							
Box	death certifica e attending pt d for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome 1 □ Live birth	of pregnancy 2 DFetal deat	th 3⊟E	Ectopic pregnanc	v		23d. Date of d	
	0 0 2	Sicia	in the past 12 months? 1 Yes 2 No 4 Pregnant a			Other (specify)	<u> </u>		Month	Day Year
о. О	The law requires that the de ste has been signed by the a page 2 should be detached f	ξ	9 bs Unknown							
	res tha igned be del	b	Part II. Other significant conditions contributing to death b	ut not resulting	in the und	derlying cause giv	en in Part I.			to the cause of death?
p	w require been signal	ed	TF US					10'	Yes 2 No 3 1	Probably 4 Unknown
ပ္ပ	law ri as be 2 sh	Completed	b, tateral CVA					24a. Was	an 24b. Were	autopsy findings available ocompletion of cause of
ř	The ate ha	E O	DIC						rmed? death?	
<u>ia</u>	Physicien: The lav this certificate has ral director, page 2	Be C	25. Was case referred to medical examiner?				26. Place of De	ath (Check only o	one)	
>	nysic lis ce direc	To	1 Yes 2 No Hospital: 1 X Inpati	ent 2 ER/C	Dutpatient	3□ DOA Ott	ner: 4 🗌 Nursing I	Home 5 ☐ Resi	dence 6 Other (Sp	ecify)
Division of Vital Records,			27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Inju (Month, Da	iry 28b.	. Time of Injury	28c. Inju	ry at	28d. Describe	how injury occurred	
<u>ত</u>	Attending ir death. •ctor: After by the fune	atic	2 Accident investigation				Yes 2 □ No			
ž	or Attending after death. Director: After in by the funer	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of In building, e	jury - At home, to. (Specify)	farm, stree	et, factory, office		28f. Location (: City or Tox	Street and Number or I wn, State)	Rural Route Number,
	itel o	Cer								
	Hospitel or 24 hours afte Funerel Dir tely filled in I	ca	29a. Certifier (Check only 2 Medical Examiner: On the basis of	of my knowledge of examination a	ge, death	occurred at the tiesting ation, in my o	me, date and place	e, and due to the urred at the time,	cause(s) and manner a date and place, and di	as stated. ue to the cause(s)
	To the Hospitel or A within 24 hours after To the Funerel Direct Completely filled in by	Medical	one) and manner st					,		
	To To	2	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mo	
1			12/ Vellion 1	7		カマ			1-08-2	004
			30. Name and address of person who completed cause of	death (Item 23a	(Type, P	rint)	1	/	ud 2)	. /
			Rubert T Peterson		TR	1C	H nuy	20115 /	V19 2)	401
	Sta Registr		31. Date filed (Month, Day, Year) 32. Rest	rar's Signature	2	Land a	U			
	negisti	ar	JAN 1 4 2004	Mar 10	- SA					

			1 - For State Registrar	State	of Maryl	and / D	epartment Certificate	of Hea	alth and M eath		iene 2 ()	04	01650
			Decedent's Name (First, Middle,	Last)						2. Date of Deat	h		3. Time of Death
	Physici /Medic		Marshall Schm	ier						January	~	Year)4	10:45 AM
No.	Examin		4a. Facility Name (If not institution,						cation of Death		4c. County		
		Н	Genesis Eldero	care Spa		Cente			apolis Under 24 Hrs.	9 Date of Birth	Anne A		
**	Funeral Director		216–20–6497	1 № M 2□F	77		rs. Months		Hours Min.	8. Date of Birth (Month, Day, June 11	Yeer) 1926	Coun	lace (State or Foreign try.) Vland
	D		Usual Residence of Decedent							oute 11	, 1520		y rand
	arylar ehow	ī	10a. State 10b. County Maryland Anne 2	Arundel	10c.	City, Town	or Location	Cro	fton			11	0d. Inside City Limits 1 ☐ Yes 2 🛂 No
	the M	ecto	10e. Street and Number	IL OIL REGIL			10f. Zip				2= Citi4 344		
	aa or	Funeral Director	1630 Eton Way				101. Zip		1114		og. Citizen of W U	.S.A	•
	death ms 23	nera	11. Marital Status	12. Was Dec	edent Ever i	n U.S.	13. Was Decede			ecify Yes or No- Rican, etc.)	14. Race	- Americ	an Indian,
92	ould be filed within 72 hours after death with the Maryland Mental Hyglene. arked other than "natural", or Items 23e or 28e-f ehow atte event, the Madical Exeminer must be notified at	y Fui	1 Never Married 2 Married	Armed F 1 G Yes If Yes, G	2 🗆 No	2 45	1 ☐ Yes 2		Mexican, Puerto Specify:	Rican, etc.)	Specify:	, White, o Wh	etc. ite
ë	hours tural	ed by	3 XWidowed 4 ☐ Divorced 15. Decedent's	Year or I	Dates: 194		Decedent's Usual	Occupation					
7	in 72 n "na Aedic	Completed	(Specify only highest	grade completed,		(Give kind of world life. DO NOT use	k done durir	n ng most of work	ing	16b. Kind of Bus	iness/inc	lustry
212	d with giene er the	mo	Elementary/Secondary (0-12)	College (1-4or 5+)			Owner			Art Ga	ller	У
p	be file tal Hy d oth	Be	17. Father's Name (First, Middle, La William Schmie					18.	. Mother's Name	(First, Middle, N	faiden Sumame)	
<u> </u>	Men Marke Marke	2											
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural; or Items 23a or 28a-f show any privative or other traumatic event, the Madical Extending mad be notified at once.	V S	-19a. Informant's Name/Relationship Morris Schmie				B5 Lake			al Route Number, Crofton,		ita te, <i>Zip</i> 114	Code)
Baltimore,	es 1 a of Hea litem rotha		20a. Method of Disposition	□ Bamaunt fram	20	b. Place of D	Disposition (Nam., crematory or ott	e of her place)	0	Date 2	20c. Location - C	City or To	wn, State
Ĕ	Pagment ant; I		1 ☐ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe	cify)			ore Crem	atory			Baltimo		
Ball	permit. Depart Import any inj		21. Sign and ov Funeral Sendee Lie	ensee (till	Zu				n M. Tay ter St.			
	N.		23a. Pert1. Enter the disease, or co shock, or heart failure. List or	emplications that by one cause on	caused the d	eath. Do no	t enter the mode	of dying, su	uch as cardiac o	or respiratory arre	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	Re	rul	(ell)	Car	in one				Onset and Death
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	d ansit	Examiner	any, Isaamy to Immediate cause. Enter Undertying Cause (Disease or injury that initiated events										
oʻ	cate be executed physician and the burial-transit	Exa	resulting in death) Last	Due to	(or as a cons	sequence of):						
8760,	ate be	dicai		d								_	
9	ding p	/Mec	IF FEMALE:	23c. If yes, ou	tcome of pre	ananou.					- 10		
Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 F nant at time o	etal death	3 ☐Ectopic pre				23d. Date Mont		y Day Year
o.	oy the arched	hysi	1 Yes 2 No 9 Unknown	9□ Unkr			o 🖂 Girior (apo	Uliy)					
C)	res that the de signed by the a l be detached t	by PI	Part II. Other significant conditions	contributing to c	leath but not	resulting in t	he underlying ca	use given in	Part I.	23e. Did toba	acco use contrib	oute to the	a cause of death?
ğ	w require been sig should b									1 ☐ Yes	s 2.⊠4No 3	∏ Proba	bly 4 □Unknown
Records,	has be	Completed								24a. Was an autopsy		ere autop	sy findings available
		Cou								perform 1 Yes 2	ed? de	ath?]Yes :	
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		_	-	Out		(Check only one	1.0		
ō	ig Phys ter this neral di	5. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date	of Injury	ER/Outp 28b. Tin		c. Injury at Work?		ne 5 Resider 28d. Describe hov			
0	uttending death. ctor; After y the funer	atior	1- Natural 5 ☐ Pending 2 ☐ Accident investigat	(Mor	ith, Day Year) Inju	ury M		2 No				
Division of	of or Attend after death Director; , d in by the f	Certification:	3 Suicide 6 Could not determine	280. Place	of Injury - A	t home, farm	n, street, factory,	affice	1	28f. Location (Stre City or Town,	et and Number State)	or Rurai	Route Number,
	pital o		29a. Certifier SPCertifying				4						
	To the Hospital or Attending Physician: within 24 hours after death within 24 hours after death of To the Funeral Director; After this certific completely filled in by the funeral director.	Medical	one) 2 Medicel Ex	Physician: To the aminer: On the b and man	easis of examiner stated.	ination and/	or investigation, i	n my opinio	on, death occurre	and due to the cau ed at the time, dat	use(s) and mani te and place, an	d due to	ited. the cause(s)
	To with	2	29b. Signature and title of certifier	1.				License nui			d. Date signed (
			My / Mu					h2.	2026		117/0	004	
			30. Name and address of pelson who	completed cau	se of death (I	tem 23a) (T	ppe, Print)	1001	mu Ch	is fer mi	32/6/	6	
	Sta		31. Date filed (Month, Day, Year)	32. F	gistrar's Si	gnature				1 ("	, -/	-	
	Registr	ar	JAN 12	2004	Com	1	Smill						

		_	For State Registrar	State of Mary		artment of H		Re	g. No.	01651
	Physicia	, 20	Decedent's Name (First, Middle, L.	ast)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Francis	Allen	Swee	1		Jan.	3 2004	6:30°M
	Examin	er	4e. Fecility Name (If not institution, gi	11	o .	4b. City, Town, or	r Location of Deat	th /	4c. County of Death	
				Sex 7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth	17 1 (pplace (State or Foreign
	Funeral			112 M 2□F	6 Yrs.	Months Days	Hours Min.		Year) Co	untry)
	Director	}	216-38-5053 Usuel Residence of Decedent		U			Fla1 . 24 ,	1937 118	ryland
	yland		10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City Limits
	Mar	ţċ	MD Ga:	rrett		0ak1ar	nd			1 ☐ Yes 2 ☒ No
	th the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	th wil		1551 Mayhew Int	Road			21550		USA	
	ems erra	Funerai	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
98	or it	y Fu	1 ☐ Never Married 2 ☐ Married	1 ⊠ Yes 2 □ No If Yes, Give		1 ☐ Yes 2 ☒ No	Specify:		Specify: W	nite
Ö	filed within 72 hours after death with the Maryland Hygiene. ther than 'natural', or tems 23a or 28a-f show int, the Madical Extratriar rount be notified at	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:	163 Dece	dent's Usual Occup	ation	1	6b. Kind of Business/	Industry
21215-0036	n 72 "naf	Completed	15. Decedent's l (Specify only highest g	rade completed)	(Give	kind of work done	during most of wo	orking	op. Kind of Businessi	industry
72	withi ene. than	Щ	Elementary/Secondary (0-12)	College (1-4or 5+)		Owner			Mari	าล
0	Hyg other ent,	Be C	17. Father's Name (First, Middle, Las	it)			18. Mother's Na	me (First, Middle, M	aiden Sumame)	
<u>a</u> n	ld be lental kad kad	To B	Harold	Francis	Swee	ne	Dora	Vic	1a	Martin
Maryland	shou ind M inar umat	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street	and Number or R	ural Route Number,	City or Town, State, Z	(ip Code)
	alth a		Alan L. Sweene/s	son	1201	Glen Cov	e Parkwa	y, Vallei	o, Ca. 945	591
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural; or Items 23a or 28a-f show amy injury or other traumatic avent, Ite Marical Examinar mast be notified at ance.	1 30	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3		Ob. Place of Disponentery, cre	osition (Name of matory or other place	ce)	Date 2	Oc. Location - City or	Town, State
Ĕ	Page nent ent: If ury o		'4 □Donation 5 □Other (Spec		Omega	Crematory	1/	6/04	Morgantown	. WV
alt	permit. Departr Importe any inje		21. Signature of Funeral Service Lice	near 1	2	2. Name and Addre	ss of Facility	Stewart Fu	meral Home	9
_	80 = 9		Biedyn	to the					Md. 21550	
No. of London	Pnysician /Medical Examiner	16	23a. Part1. Enter the disease Jor co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Due to (or as a co	nsequence of):	week the mode of dyin		nta,	/	Approximate Interval Between Onset and Death
68760,	icate be executed physicien and s the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a co						
.O. Box	the death certificat y the attending phy iched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify) _	/		23d. Date of deli Month	very Day Year
ds, P	tuires that the dei n signed by the a uld be detached f	by	Part II. Other significant conditions	contributing to death but no	y Fulti g in the t	underlying cause and	en in Part I.		acco use contribute to s 2 ☐NO 3 ☐ Pr	the cause of death?
Records,	The law requires that the cate has been signed by the page 2 should be detache	Completed						24a. Was an autopsy perform	prior to d	topsy findings available completion of cause of
Vital		Be C	25. Was case referred to medical				26. Place of De	eath (Check only one		
† <		To E	examiner?	Hospital: Inpatient	2 ER/Outpatie	nt 3□ DOA Oth	er: 4 ☐ Nursing	Home 5 ☐ Resider	nce 6 Other (Spec	cify)
ion of	Attending Phr r death. ector: After thi by the funeral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigat		ar) 28b. Time o	Wor	yat rk? Yes 2 □ No	28d. Describe how	w injury occurred	
Division	tel or Attences after death	Certification:	3 Suicide 6 Could not determine		At home, farm, si Specify)	treet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	iral Route Number,
	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	edical		Physician: To the best of maminer: On the basis of exa and manner stated.						
)	To the within 2 To the complet	Σ	29b. Signature in the objection	wx,1	MI	29c, Licens	be number	59	d. Date signed (Month	2004
		ilo	30 Name and address of person wh	completed cause of death		Print)	DHU	K, Ci	imbell	end, Mc
	Sta Regist		31. Date filed (Month, Day, Year) JAN	32. Registrats 0 5 2004	Signature	front	2	,		

			For State Registrar			epartment of Certificate of			Reg. No.	. 0:000
ï	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Harold Stansberr	У				2. Date of De Month Januar	Day Year	3. Time of Death 9:30 P. M
) *:	Examin	4	4a. Fecility Name (If not institution, give stree 426 Heather Ridge D 5. Social Security Number 6. Sex	rive	n yrs. last birtho	Frede			4c. County of Deal Frederi	ick
	Funeral Director		244-50-1859 Usual Residence of Decedent		69 Yr	Months Days		8. Date of Bird (Month, De July 7,		thplace (State or Foreign puntry) rth Carolina
	Maryland -f show lied at	tor	10a. State 10b. County Maryland Frederick	10	oc. City, Town of Freder					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the 3a or 28a at be noti	Funeral Director	10e. Street and Number 426 Heather Ridge Dr	rive		10f. Zip Code 2170)2		10g. Citizen of What Co United St	•
036	be filed within 72 hours after death with the Maryland Hygiene. d other then "natural", or items 23a or 28a-f show event, the Modical Examiner must be notified at	þ	A	Vas Decedent Eve Armed Forces?	3–1957	13. Was Decedent of If Yes, specify Cu		pecify Yes or No o Rican, etc.)		
21215-0036	within 72 hor ne. hen "natur e Medical E	Completed		npleted) College (1-4or 5+)	(6	ecedent's Usual Occu Give kind of work don- ite. DO NOT use retir	eduring most of wor ed)	king	16b. Kind of Business	Industry (
ณ เ	be filed stal Hygi od other event,	To Be Co	12 17. Father's Name (First, Middle, Last) James Edward Stansb	erry	MBC	Idilical Desi	7		Maiden Sumame) ne Barker	
Š	d 2 s th ar 7 ls 1 rau		19a. Informant's Name/Relationship (Type, I Della Mae Stansberry						er, City or Town, State, I lerick, MD	Zip Code) 21702
Baltimore,	permit. Pages 1 and Depertment of Heali Important: If Item 2 eny injury or other 20058.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo '4 ☐ Donation 5 ☐ Other (Specify)	val from State	cemetery,			Pate ary 7	20c. Location - City or Washington	
Bai	permit Deper Impor eny in	(21 Signature of Juneral Service Licensus	Sterch	~	P.O. Box		shington	p.C. 200	37 Approximate
	death certificate be executed Water and Market and Articles and Articles as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of)	:	ing, such as cardiac	or respiratory at	1001,	Interval Between Onset and Death
	death certiff e attending ed for use as	Physician/Mec	in the past 12 months?	f yes, outcome of p □ Live birth 2 □ □ Pregnant at time □ Unknown	Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су		23d. Date of de Month	ivery Day Year
ds, P.O	law requires that the de as been signed by the a 2 should be detached t	þ	Part II. Other significent conditions contribu	uting to death but n	ot resulting in t	he underlying cause g	iven in Part I.		obacco use contribute to	
<u> </u>	The ate h	Completed						24a. Was autor perto 1 Yes	rmed? prior to death?	topsy findings available completion of cause of
V Its	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	tal:	- 5		26. Place of Dea			
on of	Phys this aldu	ıtlon: To	TO THE ZIENO	1 ☐ Inpatient Ba. Date of Injury (Month, Day Yo	2 ER/Outp 28b. Tin lnji	ne of 28c. Injury	4 🗆 Nursing n		dence 6 Other (Spe	city)
Divis	To the Hospital or Attending, within 24 hours after death. To the Funeral Director; After completely filled in by the funer	Certification:	o □ Could not be	Be. Place of Injury building, etc. (- At home, farm Specify)	s, street, factory, office)	28f. Location (S City or Tov	Street and Number or Ro wn, State)	urel Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (29a. Certifier (Check only one) 1 Certifying Physicial 2 Medical Examiner:		amination and/	or investigation, in my	opinion, death occu	rred at the time,	date and place, and due	to the cause(s)
	To t To t com	Σ	29b. Signature and title of certifier				ise number		29d. Date signed (Mont	
l	6		1		70		-31912		1/08/	04
0	Sta Registr		30. Name and address of person who complete the complete that the	32. Registrar	h (Item 23a) (T	ype, Print) 3 m 7 own	barker	neden	ich, mo	2076

			for State Registrar	State of Maryla		artment of F		_	_	2001	01652
4.			Registrar 1. Decedent's Name (First, Middle, Last)		061	lineale of	Deam	2. Date of De	Reg. No.	- U U Y	3. Time of Death
İ	Physicia /Medic		Alice Sarah E		ummers	5		Januar	Day	, 2ď04	
	Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, o	r Location of D	eath	4c.	County of Death	1
			Frederick Memoria	l Hospital			erick			Frederi	ick
	Funeral		Social Security Number 6. Sex	M SIXE	. last birthday)	If Under 1 Year Months Days		Hrs. 8. Date of Bird Win. (Month, Da	th y, Year)	9. Birth	nplace (State or Foreign untry)
	Director		217-28-5962 Usual Residence of Decedent	8	8 Yrs.			March 2	28, 1	.915 Ma	ryland
	yland		10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	Mar	tor	Maryland Frederick		Jeffer	son					1 ☐ Yes 2X No
	r 284	Lec	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Co	untry?
	th wit	Funeral Director	3324 Jefferson Pik	e		2	21755		Uni	ted Sta	ites
	dea	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. V	Vas Decedent of H	lispanic Origin	? (Specify Yes or No uerto Rican, etc.)	- 1	4. Race - Amer Black, White	
ထ္	after or Ite	F.	1 ☐ Never Married 2 XMarned	1 ☐ Yes 2 X No If Yes, Give		Yes 210 No	Specify:	30.10 7.104.1, 510.7		Specify: Whi	
8	ural',	d by	3 Widowed 4 Divorced	Year or Dates:		2.00	0,000,00			Specily. WIII	
2	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show the Madical Exemples must be notified.	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced (Give	lent's Usual Occup kind of work done OO NOT use retired	ation during most of	working	16b. Kir	d of Business/I	ndustry
7	vithin ne. han	dm	Elementary/Secondary (0-12)	College (1-4or 5+)		sembler	d)			Ontion	
2	lied v tygie her t	ပိ	17. Father's Name (First, Middle, Last)		AS	Sembrer	19 Matharia	Nome /First Middle		Optical	-
JUG B	be fi	Be						Name (First, Middle,		,	
<u> </u>	should be Ind Mental I marked o	မှ	Roy A. Cline		405 14:33	A 11 (2)		Clara B. (
Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic svent, the Medical Expirition must be notified at once.		19a. Informant's Name/Relationship (Ty) Charles H. Summers					r Rural Route Numbe Jefferson	-		
	1 and Health		20a. Method of Disposition		Place of Dispo		I IIKE	Date		ation - City or 1	
Baltimore,	Peges nent of h ant: If ite ury or of		1 Denial 2 Cremation 3 R	emoval from State	cemetery, cren	natory or other plac					
Ë	t. Pe tmen tant:		'4 □Donation 5 □Other (Specify)			et Cemete	,				Maryland
3a	Deparenti Deparenti Importanti Eny ir		21. Signature of Funeral Service License	M // '				Stauffer Pike Free			le land 21702
_	40 = # d		ountrey	11 Jathes						K, Mary	
	Physician		23a. Part1. Enter the disease, of dompli shock, or heart failure. List only or Immediate Cause (Final disease or condition	/	naestive	Heart Fail		diac or respiratory ar	rest,		Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a conse		TICALL TOTAL					100042
	Examiner										
		Der	if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):						
	te be executed ysician and te burial-transit	Examiner	Cause (Disease or injury that initiated events								
o,	an ar rial-ti	EX	resulting in death) Last	Due to (or as a conse	quence of):						
760,		cal									
89	leath certificat attending phy I for use as th	led	in course							200.100	7
Вох	h cer endir use	Z V	23b. Was decedent pregnant	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fel		Ectopic pregnancy	,		2:	3d. Date of delin	very
ω.	deat	sicie	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 Pregnant at time of		Other (specify)				Month	Day Year
Ö.	t the by th tache	hys	9 🗆 Unknown	9□ Ouknown							
S, D	es that the death igned by the atte be detached for	by Physician/Med	Part II. Other significant conditions con	tributing to death but not re	sulting in the ur	iderlying cause giv	en in Part I.	23e. Did to	obacco us	e contribute to	the cause of death?
ğ	w require been signature		Hypertension					_ 1 U Y	∕es 2.⊊	No 3□Pro	babiy 4 Dunknown
SCO	awres be	Completed	Domentia					24a. Was		24b. Were aut	opsy findings available
Ä	The lay te has	E	Mulhale Hycloma						rmed? 2 No	death?	ompletion of cause of
Vital Records,	ician: Th certificate rector, pag	BeC	25. Was case referred to medical				26. Place of	Death (Check only o		10 100	20,110
	ysician: The la is certificate has director, page 2	0	examiner? 1 Tes 2 No	ospital:	ER/Outpatien	1 3□ DOA Oth		ng Home 5 ☐ Resid		□Other (Speci	ifv)
0	ding Phy h. After thi funeral	Liu	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injun	y at	28d. Describe h			
<u>o</u>	nding lath. r: After e funer	atlo	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	(MONIN, Day Yoar)	Inquity		Yes 2 □ No				
Division of	or Attendater deatl Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, stre	et, factory, office		28f. Location (S City or Tow	Street and	Number or Rui	al Route Number,
	s after s after of Dire	Cert		building, etc. (opec	··y)			City of You	ni, State)		
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as it		29a. Certifier 1 Certifying Phys	ician: To the best of my kr	owledge, death	occurred at the tin	ne, date and pl	ace, and due to the	cause(s) a	and manner as	stated.
	he H in 24 he F plete	Medical	one)	and manner stated.	attori and/or inv	estigation, in my o	pinion, death o	ccurred at the time, (date and p	olace, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	-1.0		29c. Licens				signed (Month,	4.
•			SM	Men M.D.		000	5579	5	/	-4-	07
	7		30. Name and address of person who co	mpleted cause of death (ite	m 23a) (Type, I			1 1 1	A	44 ^	
_			610 Solarex	Ct , trederic	K MD	21703	51	iresh K. I	Whon	M.D.	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	6 1	200 N.	/		•	
	Registr	OF.	E 1.3 9% cm %	1 / HIE14		1 12.69.	· VICEON				

	_	= State Registrar			Ce	ertificate	of Death		lygien Reg. N	_ 4 4 4	4 016
Physiciar /Medica	n	Decedent's Name (First, Middle Emma	le, Last) Louise	9	Smi	th		2. Date of Month Janua	D	ay 2004	3. Time of Dear
Examine	_	4a. Facility Name (If not institution	n, give street and nu	ımber)		4b. City, Tov	n, or Location of	Death	4	c. County of De	
		Southern Mar		spital			inton				George's
Funeral Director		5. Social Security Number 579–20–5972	1	7. Age (In yrs. 82	last birthday Yrs.	Months D	ear If Under 2 ays Hours	Min. 8. Date of (Month, Aug.)	Birth Day, Year 20,1	921 Vi	lirthplace (State or Fo Country) rginia
A ST	-	Usual Residence of Decedent 10a. State 10b. County	· · · · · · · · · · · · · · · · · · ·	10c. Cit	ty, Town or I	_ocation					10d. Inside City Li
"natural", or Itams 23a or 28a-f show idical Examiner must be nutified at idical hy Ermeral Director	0	Maryland Prince	e George's	5	Uppe	r Marlbo	oro				1 ☐ Yes 2 €
r 28s	Director	10e. Street and Number				10f. Zip Co			10g. C	itizen of What	Country?
23a c		9017 Columbine	e Lane			207	72			U.S.A	•
or Itams	Funerat	11. Maritat Status	Armed F	cedent Ever in U orces?	J.S. 13	. Was Decedent If Yes, specify	of Hispanic Orig Cuban, Mexican,	in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - An Black, Wh	nerican Indian, nite, etc.
and a	DY	1 Never Married 2 Mar 3 Widowed 4 Divorced	ried 1 ☐ Yes If Yes, G	2. ZNo ive XX Dates:		1 ☐ Yes 2 ☐	Kno Specify:			Specify:	White
al E		77 (51-14)	nt's Education	Jai65.	16a Dec	edent's Usual O	ocupation		16b i	Kind of Busines	se/Industry
Aggregate of the state of the s	Completed	(Specify only highe	st grade completed)	(1-4or 5+)	(Giv life.	e kind of work d DO NOT use re	ccupation fone during most etired)	of working	100.	Tano or busines	Samoustry
the Me	E	Elementary/Secondary (0-12)	College ((1-401 5+)	Bool	kkeeper			Pi	rivate	
event, the Me	Bec	17. Father's Name (First, Middle,					18. Mother	's Name (First, Mid	dle, Maide	n Sumame)	
7 le marked other traumatic event, L To Be Co	0	Robert L. McE	Elwee				Ger	tie M	IcCul.	lough	
sician emportant:		21. Signatury of Funeral Service 23a. Part1. Enter the disease, o shock, or heart failure. List tmmediate Cause (Final disease or condition resulting in death)	r complications that t only one cause on	00153		22. Name and A	ns Cemete ddress of Facility Id Alexai dying, luch as c	Lee Fur ndria Fer	eral ry Ro	Home,	Inc. Approximate Interval Bervie Conse and year
or use as the burial-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c	o (or as a consequence of pregnibirth 2 Feta	quence of): ancy al death 3	Ectopic pregn		ty?	_	23d. Date of d Month	24h 24h elivery Day Year
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Physician /Medical Examiner Carl Sanford Shyman 4a. Facility Name (If not institution, give street and number) Montgomery General Hospital 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 6. Sex 1 N Age (In yrs. last birthday) 78 Yrs. 78 Yrs. Toc. City, Town, or Location of Death Montgomery 4c. County of Death Montgomery 9. Birthplace (State or Fon Country) Country) Seattle, Wash Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lim			1 - State Registrar Amer:d Item#26p	State of Marylar erVERI;ALG828 2/2	nd / Depa 1/04 G #	artment of H rtificate of	lealth an <i>Death</i>	d Mental Hy	giene Reg. No. 2 (04	0165
Montgomery General Hospital The Second Security Number The Second Security Number The Second Security Number The Second Seco			Carl Sanford Sh	yman				January	Day		3. Time of Death 10:03A. M
State - 12 - 4450 Type - 12 Type - 1			Montgomery Genera	l Hospital		Olney			Mont	gomer	-
100. States 100. Country 100. Country 100. Country 100. The process 100. States 100. S	Director		534-12-4450					Win. (Month, De Dec 31	, 1925	Cour	ten()
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Trying Shyman -wife 19	ours after dee	þ	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No		f Yes, specify Cuba	an, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	Bla	ck, White,	etc.
The informant's Name April Apple Name (1) to be informant's Name Apple (1) to be informant's Name A	d within 72 hagiene.	ompleted	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of d)	working	Westing	thous	e
20a. Memor of Disposition (Name at 2 Contract Course (Speechy) 21. Signature (Speechy) 22. Signature (Speechy) 23. Signature (Speechy) 24. Signature (Speechy) 25. Signature (Speechy) 26. Signature (Speechy) 27. Signature (Speechy) 28. Signature (Speechy) 29. Signature (Speechy) 20. Memor of Disposition (Name at 2 Contract (Speechy)) 20. Signature (Speechy) 20. Memor of Disposition (Name at 2 Contract (Speechy)) 21. Signature (Speechy) 22. Signature (Speechy) 23. Signature (Speechy) 24. Signature (Speechy) 25. Signature (Speechy) 26. Signature (Speechy) 27. Signature (Speechy) 28. Place of Disposition (Name at 2 Contract (Speechy)) 29. Signature (Speechy) 29. Signature (Speechy) 29. Signature (Speechy) 20. Memor of Disposition (Speechy) 20. Memor of Disposition (Speechy) 20. Signature (Speechy) 21. Signature (Speechy) 22. Signature (Speechy) 23. Signature (Speechy) 24. Signature (Speechy) 25. Signature (Speechy) 26. Signature (Speechy) 27. Signature (Speechy) 28. Was case referred to medical experiment of the cause of the death of place of delivery (Speechy) 28. Was case referred to medical experiment of the cause (Speechy) 28. Was case referred to medical experiment of the cause (Speechy) 28. Signature (Speechy) 29. Signature and Policy (Speechy) 29. Signature (y call of hould be file d Mental Hy narked othe natic event,	Be	Irving Shyman	Original Control	40. 11. 11		Vivia	n Lurie	Maiden Suman	ne)	
Provided Control Table Provided Control Ta	Peges 1 and 2 st lent of Health and nt: If Item 27 is n rry or other treum		Helouise J. Shyman 20a. Method of Disposition 12 Burial 2 Cremation 3 DR	n -wife	13713 Place of Dispo	Mills Assition (Name of natory or other place	venue S	Silver Spr Date	ing, Mai	rylan - City or To	d. 20904 wn, State
23a Part English and spasses or completators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate models of cause (Final disease or condition) and the cause of the cau	permit. Departm Importa eny inju		21. Signatury 1 Juneral Set ice Licens	an tust	DC 44	nald V. 1 00 Powder	ss of Facility Borgwar Mill	dt Funera Rd. Belts	l Home, ville, N	- 770	
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25. Was case referred to medical examiner? 1	the death certificat y the attending phy ched for use as the	ysician/Medi	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ Feter 4 ☐ Pregnant at time of di	death 3						
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and dates of person who completed cause of death (Item 23a) (Type, Print) Matthew Connolly, M.D. 18109 Prince Philip Dr., #225 Olney, Maryland 20832	i: The law recate has be							autop perfor	rmed?	prior to com death?	pletion of cause of
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and didenses of person who completed cause of death (Item 23a) (Type, Print) Matthew Connolly, M.D. 18109 Prince Philip Dr., #225 Olney, Maryland 20832	tending Physiciar eath. or: After this certif the funeral directo	ToB	examiner? 1 Yes 2 No 27. Manner of Death XX Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 🔏	28b. Time of	28c. Injun World	er: 4 □ Nursin at c?	g Home 5 Resid	lence 6 Oth)
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30. Name and address of person who completed cause of death (Item 23a) (Type. Print) Matthew Connolly, M.D. 18109 Prince Philip Dr., #225 Olney, Maryland 20832	fo the Hos vithin 24 hd fo the Fun completely it	Medica	one)	1er: On the basis of examinat	wledge, death tion and/or inv	estigation, in my op	oinion, death o	ccurred at the time, o	date and place, a	and due to	the cause(s)
Matthew Connolly, M.D. 18109 Prince Philip Dr., #225 Olney, Maryland 20832			30. Name and address of person who co	mpleted cause of death (Item	23a) (Tvna 1	Print)		39	ilsle	>4	
	Sta	ite	Matthew Connolly,	M.D. 18109 P	rince :	Philip Dr	., #22!	5 Olney, M	Maryland	2083	2

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Physicia		1. Decedent's Name (First, Middle, Last) VIRGIE TAUHEEDA SAL	LEEM			2. Date of Death Month Jan. 3, 2	004 Yeer	3. Time of Death 9:20a M
/Medic Examin		4a. Fecility Name (If not institution, give street and number) 4739 68th Pl.			Location of Death		4c. County of Deetl	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last to 578 - 28 - 9523	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, Ye. Mar. 17,	9 Birth	nplace (State or Foreign untry) North Carolina
death with the Maryland me 23a or 28a-f ehow grans be neithed at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, To Raryland Prince Geo. La		ver Hil	1 s			10d. Inside City Limits 1 XYes 2 No
with the	Direc	10e. Street and Number 4739 68th Pl.		10f. Zip Code 2078	4	10g.	Citizen of What Co	untry?
i i i	by Funeral Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo If Yes, Give	lf If	as Decedent of Hi	spanic Origin? (Spin, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: B]	e, etc.
Z I 3-0036 tthin 72 hours at ie. ten "natural", or Wedical Exam	Completed b		(Give k	O NOT use retired,	furing most of work	ing	. Kind of Business/	ndustry
Maryland ZIZI 2 should be filed within 7 h and Mental Hygiene. 7 ie marked other then * fraumatic event, the Med	To Be Cor	11 17. Father's Name (First, Middle, Last) John Allen			18. Mother's Name	First, Middle, Maid Smith	den Sumame)	
mad 2 shoul and 2 shoul waith and Mark 127 to mark er traumati	-	Veronica Raynor- Daughter	4739	68th P	1,Lando		s,Maryl	and 20784
Pages 1 ament of He ant: If then ury or oth		1 M Rurial 3 Cramation 3 Removal from State Ceme	. Was	tion (Name of atory or other place h . Cemet	. 1-8-	04 A d	elphi, M	d .
Dairi permit. Departri Importa eny inju		21. Signature of Funeral Service Licensee	4	11Kenne	dy St,N	.W.,Wash		
Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Breast C disease or condition resulting in death)	arci		g, such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death
Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Chickeas or injury						
ote be executed cate be executed physician and the burial-transit	dicai Examine	that initiated events resulting in death) Last C. Due to (or as a consequence d	ce of):					
death certifi death certifi e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea Pregnant at time of death 9 Unknown 1 Unknown 1 Live birth 2 Fetal dea Pregnant at time of death 9 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown	ath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of deli	very Day Year
Hecords, P.O. The law requires that the te has been signed by the age 2 should be detache	þ	Part II. Other significant conditions contributing to death but not resulting	ng in the und	derlying cause give	en in Part I.			the cause of death?
	Completed					24a. Was an autopsy performed	? prior to death?	topsy findings available completion of cause of
Of VItal Ke Physician: The la this certificate ha: ral director, page 2	o Be	25. Was case referred to medical examiner? 1 Yes 2 X No Hospital: 1 Inpatient 2 ER/	/Outpatient	3□ DOA Othe	20	me 5X Residence	6 ☐ Other (Spec	iity)
ding h. Atter	Certification: T	1 XNatural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	b. Time of Injury	28c. Injury Work M 1 []`	/ at ⟨? Yes 2 □ No	28d. Describe how in		
DIVISION Spital or Attensours after deat seral Director: filled in by the		4 Homicide determined 256. Place of injury - At home, building, etc. (Specify)	, farm, stre	et, factory, office		28f. Location (Street City or Town, St	and Number or Ru ate)	rai Route Number,
To the Hospital within 24 hours a To the Funeral I completely tilled	edicai	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowled to the best of my knowled and manner stated.						
To the within 2 To the complet	Σ	29b. Signature and title of certifier		29c. License	5963		Date signed (Month	2004
		30. Na no do of person who completed cause of death (Item 23. Glen Jacob, MD 12.		rint)		Largo,Md	2077	4
Sta Registi		Date filed (Month, Day, Year) JAN 0 7 2004 32 Registrar's Signature		Sporks	111-1	g o , , r u	2077	

		•	1 - For State Registrar	tate of Maryland /		ent of He ate of D			iene 20	04 016	57
	Physicia		Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Y	3. Time of De	
	/Medic	al	GERTRUDE J. 4a. Facility Name (If not institution, give stree	SCHILLER t and number)		ily Town or l	ocation of Death	JANUARY	5 200 4c. County of		Ам
	Examin	er		Road-Casey Ho	1	Rockvi				jomery	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M	2	birthday) If Ur Yrs. Mon		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept. 25	, 1918). Birthplace (State or F Country) New York	Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location					10d. Inside City	Limits
	Maryl	tor	Md. Montgomer	y Gai	thersbu	rg				1 ☐ Yes 2	2⊠No
	th the	lrec	10e. Street and Number		10f	Zip Code		1	0g. Citizen of Wh		
	ath wi	ral	23713 Eli Lane		10.111 - 5		20882	-4. V N-	United	States American Indian,	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23e or 28e-f show amounts into yo other traumatic event, the Medical Exame in chart be notified at once.	Completed by Funeral Director	1 Never Married 2 Married 1	Vas Decedent Ever in U.S. Armed Forces? I □Yes 2 BNo I Yes, Give Year or Dates:		_/	panic Origin? (Spec Mexican, Puerto F Specify:	Rican, etc.)		White, etc. White	
5	72 ho	eted	15. Decedent's Educatio (Specify only highest grade cor		6a. Decedent's (Give kind o	Jsual Occupati work done du	on ring most of workin	g	16b. Kind of Busi	ness/Industry	
12	within ene. then	Jumo	Elementary/Secondary (0-12)	College (1-4or 5+)	Homema				Own Hon	ne	
d 2	I Hygi other	Be Co	17. Father's Name (First, Middle, Last)		710111011101		8. Mother's Name	(First, Middle,	Maiden Sumame)		
/lan	wild be Menta arked artic ev	To B	Thomas Lyons				Frances			· · · · · · · · · · · · · · · · · · ·	
, Maryland	and 2 sho nath and i n 27 is mu ar trauma		19a. Informant's Name/Relationship (Type, I Jean F. Smedira /	Daughter	23713	Eli Lar	ne, Gaith	ersburg	, Md.	20882	
Baltimore,	Pages 1 ment of He ant: If iten ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify)	wal from State Ceme	of Disposition etery, crematory (lawn Ce	or other place)				e, Marylan	nd
Balt	permit. Departimport any inj		21. Signature of Funeral Service Licensee **Multiple H. I.	Barber	Р.	0. Bo		Laytons	ville, N	Md. 20882	
	Physician		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one of immediate Cause (Final disease or condition	ons that caused the death. Dause on each line. END STAGE CHR						Approximate Interval Betwee Onset and De	en eath
100	/Medical Examiner		resulting in death)	Due to (or as a consequence							
b	Lxammer	7	Sequentially list conditions, b. — if any, leading to immediate	Due to (or as a consequence	ce of):						
	petri	Examiner	cause. Enter Underlying Cause (Disease or injury	540 (0 (0: 40 2 50::00425::0	0.7.						
oʻ	cate be executed physician and the burial-transit	Еха	that initiated events c resulting in death) Last	Due to (or as a consequence	ce of):		-				
8760,	ate be hysicii the bu	dlcal	d								
O. Box 6	death certifi e attending d for use as	Physician/Med	in the past 12 months?	If yes, outcome of pregnancy 1∐Live birth 2 □ Fetal dea 4□ Pregnant at time of death 9□ Unknown	ath 3 ☐ Ectop	ic pregnancy r (specify)			23d. Date Monti		ar
٥	89 69	by	Part II. Other significant conditions contrib ADVANCED DEMENT	-	ig in the underlyi	ng cause given	in Part I.			ute to the cause of dea	
Vital Records,	The taw requir ate has been si page 2 should i	Completed						24a. Was a autops perform	sy pri med? de	ere autopsy findings avor to completion of cau ath?	railable use of
/ita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ital		Other	26. Place of Death				
	d is	. To	1 Yes 2 No Hosp	8a. Date of Injury 28	Outpatient 3D	DOA	4 Indising Hon		ence 6 Other		ice
lon	Attending Ph ir death. ector: After th by the funeral	atlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	28c, Injury a Work? 1 ☐ Ye	es 2 □No		, ,		
Division of	after death	Certification:	CO Could not be	8e. Place of Injury - At home building, etc. (Specify)	, farm, street, fa	ctory, office	2	8f. Location (S City or Town		or Rural Route Numbe	er,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C		n: To the best of my knowled On the basis of examination and manner stated.							
	To the I within 2 To the I	Me	29b. Signature and title of certifier			29c. License	number	2	29d. Date signed	Month, Day, Year)	
)	3		CHUCK!	1/ch		DØØ	4121	8	01/0	15/04	
		400	30. Name and address of person who compl CHARLES HARRISON,		3a) (Type, Print) 5 PICCAI	RD DRIV	E, ROCK	VILLE,	MD. 208	50	
	Sta Regist		31. Date filed (Month, Day, Year) JAN 0 7 2004	32. Registrar's Signature		back	/				

		1 - For State Registrar	State of Marylan	d / Depa		Health and	Mental Hygi	iene -	4 01658
Physic	ian	1. Decedent's Name (First, Middle, Last					2. Date of Death Month	n	3. Time of Death
/Medi Exami		Jayaraj Sathyashee 4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Dea	1-1-04	4c. County of I	12:35 P.M
		Holy Cross Hospita			Silver If Under 1 Yea		B Date of Birth	Montgo	
Funeral Director	,	5. Social Security Number 6. Se 15 215-62-6030 Usual Residence of Decedent	x 7. Age (In yrs. 68	Yrs.	Months Day			9. 935	Birthplece (State or Foreign Country) India
Maryland f show	tor	10a. State 10b. County MD Prince G		y, Town or Lo					10d. Inside City Limits 1 🖾 Yes 2 □ No
with the	Direc	10e. Street and Number	corge 5 RIV	Cluare	10f. Zip Code		10	Og. Citizen of Wha	t Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	oy Funerai	6625 61st P1. 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		20731 Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 ☑ N		Specify Yes or No- to Rican, etc.)	14. Race - A Black, N	American Indian, White, etc. East Indian
in 72 hour	ojeted t	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	dent's Usual Occ kind of work don OO NOT use retii	e during most of wo	orking	l6b. Kind of Busin	
od with giene. er ther	Comp	Elementary/Secondary (0-12)	College (1-4or 5+) 2	Accour	ntant			Hotel Ir	dustry
uld be file Aental Hy rked other tic event	To Be	17. Father's Name (First, Middle, Last) Rangappa Sathyash	eelappa				me <i>(First, Middl</i> e, <i>M</i> a Marappa	faiden Surname)	
nd 2 should be alth and h 27 is main r trauma		19a. Informant's Name/Relationship (7) Vinaya Sathyashee1			_		ural Route Number, ale, MD 20		te, Zip Code)
ages 1 and the sant of Head		20a. Method of Disposition 1 □ Burial 2 ⊋Cremation 3 □ R 4 □ Donation / 5 □ Other (Specify)	Removal from State	emetery, cren	sition (Name of natory or other pi ark Crem			oc.Location - City	
permit. P Departme Importsn eny injur		21. Signature of Funeral Service Ligens		22	. Name and Add	ress of Facility H	nes-Rinal	di F. H.	
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the deat ne cause on each line.						Approximate Interval Between Onset and Death
Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a conseq Coronary ar		isease				
te be executed ysicien and he burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a conseq Cerebrovasc Due to (or as a conseq	ular s	troke				
The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	death 3	Ectopic pregnan Other (specify)	су		23d. Date of Month	delivery Day Year
uires that signed by Id be deta		Part II. Other significant conditions co	ntributing to death but not res	ulting in the ur	nderlying cause g	rven in Part I.			te to the cause of death? Probably 4 XUnknown
The law requir ate has been si page 2 should	Completed						24a. Was an autopsy perform	ed? prior	e autopsy findings available to completion of cause of h? Yes 2 \[\] No
Physiclan: The rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			ther	ath (Check only one		
ling Phys h. After this tuneral dir	ion: To	27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inj	4 Li Nursing i	dome 5 ☐ Resider 28d. Describe how	<u></u>	Specify)
To the Hospital or Attanding Physiclan: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, it	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, stre			28f. Location (Str. City or Town,		r Rural Route Number,
Hospits 24 hours Funerel etely filler	Medicai C		sician: To the best of my kno ner: On the basis of examina and manner stated.						
	Me	29b. Signature and title of certifier	1.D. Potel J	ayanı		nse number		d. Date signed (M	onth, Day, Year)
10		30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, I	Print)			111	- 1
Sta Regist	ate	Patel Jayanh, M. D 31. Date filed (Month, Day, Year)	. c/o Holy Cro 32. Registrar's Signa	oss Hos	Sp. 1500		len Rd. S	ilver Sp	ring, MD 209

			for Stete Registrer	State of Mary	land / Dep		alth and Me	ental Hygie	•	4 01659
	Physici	an	1. Decedent's Name (First, Middle, Last					2. Date of Death Month	Day Yea	3. Time of Death
	/Medio	cal	Albert M. Sch: 4a. Facility Name (If not institution, give Holy Cross Ho	street and number)		4b. City, Town, or Lo		January	1, 2004 4c. County of De Montgome	
	Funeral Director		5. Social Security Number 579-28-2111 Usual Residence of Decedent	x 7. Age (In A 2 ☐ F	yrs. last birthday) 76 Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Sept. 17,	9. B 1927 Né	irthplace (State or Foreign Country) EW York
	Maryland a-f show	tor	10a. State 10b. County Maryland Montgome:		c. City, Town or Lo Silver Si					10d. Inside City Limits 1 Yes 2 □ No
	ath with the 23a or 28 ust be not	ral Director	10e. Street and Number 3005 S. Leisure We					I	. Citizen of What o	Country?
036	within 72 hours after death with the Maryland ene. then "naturel", or Items 23a or 28a-f show the Modeul Exercities is used by modified at	by Funeral	11. Marital Status 1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:	TW 2 Army	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 \$\overline{\Omega}\$ No	eanic Origin? (Spec Mexican, Puerto F Specity:	ify Yes or No- lican, etc.)	14. Race - Ar Black, Wh Specify:	nerican Indian, nite, etc. White
Maryland 21215-0036	within 72 ho ene. then "natur	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	completed) College (1-4or 5+) 2 Years	(Give	dent's Usual Occupation I kind of work done dur DO NOT use retired) chant	on ing most of workin	g 16	b. Kind of Busines Dry Cle	
yland 2	ould be filed within Mental Hygiene. arked other then arice event, It a Matic event, It a Matic event, It a Matic event, It a Matic event.	e	17. Father's Name (First, Middle, Last) Julius Schindler				8. Mother's Name Goldie E			<u> </u>
	l and 2 sho lealth and im 27 is m ber treum		19a. Informant's Name/Relationship (T) Nita J. Schindler	- Wife	3005	ng Address (Street and S. Leisure		31vd., Ag	tyland,	Silver Sprin
Baltimore,	nit. Pages 1 and 2 should by artment of Health and Ments ortent: If item 27 is marked injury or otber treumatic eig.		20a. Method of Disposition 1 □ ☐ Unit of Disposition 1 □ Output of Disposition 2 □ Cremation 3 □ Other (Specify, output of Disposition) 21. Signature of Funeral Service □ Cens)	Judean M	osition (Name of matory or other place) emorial Ga:	rdens 1/5	5/2004		ryland
Ba	permit. Departing Importe any inji		Donald !	Stattles	ruer	Name and Address Anzansky-Go 170 Rockvi	lle Pike.	Rockvi1	le. Mary	land 20852
b	Frrysician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Metas	tatic Ca	cinoid Tum	such as cardiac or	respiratory arrest		Approximate Interval Between Onserand Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a co	Cancer					1 Year
,092	te be executed ysician and ie burial-transit	cal Examiner	resulting in death) Last	c. Due to (or as a co		t Disease				5 Years
.O. Box 687	e death certifica he attending ph led for use as th	Physician/Medic	IE FEMALE:	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)		- //-	23d. Date of d Month	elivery Day Year
<u>α</u>	w requires that the been signed by t should be detach	þ	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the u	nderlying cause given	in Part I.			to the cause of death? Probably 4 Unknown
Vital Records,		Completed						24a. Was an autopsy performed	prior to death?	
	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 🛣 Inpatient	2 ER/Outpatier	Other	6. Place of Death		e 6 □Other (Sp	ecify)
Division of	ing After une	Certification:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time o Injury	Work?	s 2 No	3d. Describe how		
Divi	itel or Attend irs after death ral Director: , ral bir by the f		4 Homicide determined	28e. Place of Injury - building, etc. (S	pecify)			City or Town, S	State)	Rural Route Number,
	To the Hospitel or within 24 hours after To the Funeral Director Completely filled in E	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medicel Exem	sicien: To the best of my iner: On the basis of exa and manner stated.	/ knowledge, deat mination and/or in	h occurred at the time, vestigation, in my opin	date and place, ar ion, death occurred	nd due to the caus d at the time, date	e(s) and manner a and place, and du	as stated. ue to the cause(s)
	Parity Mithing	M	29b. Signature and title of certifier	Z M		29c. License n		29d.	Date signed (Mor	nth, Day, Year)
	l -		30. Name and address of person who c	der (03)		Print)	_ # 30	b 551	uel 20	902
	Sta Regista		31. Date filed (Month, Day, Year) JAN 0 7 20	32. Registrar's S	Signature	Spark	/			

			1 - For State Registrar	State of Ma			rtment of H		nd M		iene _{eg. No.} 2	004	01660
	Dhyoisi		1. Decedent's Name (First, Middle, Last)						2. Date of Dear	th Day	Yeer	3. Time of Death
Ĺ	Physici /Medio		Anna Josephine	Schneider						January		004	9:35 ам
1	Examir		4a. Facility Name (If not institution, give				4b. City, Town, or		Death			y of Deeth	
	· · · · · · · · · · · · · · · · · · ·		Suburban Hospit				Bethes		4 lden			gome	
	Funeral Director		5. Social Security Number 6. Se 281-32-6242	× /. Age	(In yrs. last bir 81	thday) Yrs.	Months Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day July 12	Year)	Cou	place (State or Foreign ntry) Tmany
	land w		10a. State 10b. County		10c. City, Tow	n or Loc	ation						10d. Inside City Limits
	Mary -1 sh	ţō	Maryland Montgomen	rv	Germa	nto	พก						1 ☐ Yes 2 ☒No
	r 28a	Director	10e. Street and Number	7	0021110		10f. Zip Code			1	0g. Citizen of	What Cou	ntry?
	23e o		11537 Doxdam Ter	crace			208	76			U	ISA	
21215-0036	72 hours after death with the Maryland "natural", or Items 23e or 28a-1 show officel Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Amarried 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		if	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 No	ispanic Origin, Mexican, Specify:	in? (Spe Puerto F	cify Yes or No- Rican, etc.)	Bla	ce - Ameri ck, White, fy: White	
2-0	72 hg	eted	15. Decedent's Edu (Specify only highest grad	cation	16a.	Deced (Give	ent's Usual Occupa	ation	of workir	20	16b. Kind of E	Business/Ir	dustry
121	d within 72 ho piene. r than "natu the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	oo <i>not use retired</i> emaker	1)		.3	Ora	n Hor	
d 2	e filed al Hygie other vent, il		17. Father's Name (First, Middle, Last)			пош	emaker	18. Mother	s Name	(First, Middle, I			ne .
lan	should be nd Mental marksd o	To Be	Josef Volk	mar						ephine E			
Maryland	S S E E	_	19a. Informant's Name/Relationship (T)	rpe, Print)	19b	Mailin	g Address (Street a					, State, Zij	Code)
	1 and 2 Health a em 27 is		Willie Schneider/	Husband	1	153	7 Doxdam	Terra	ce,	Germant	own, M	D 208	376
ore	of Hez of Hez Hitem or othe		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ F	Removal from State	cemeter	ry, crem	ition (Name of atory or other plac	e) J		ate ry 10	20c. Location	- City or T	own, State
Ĕ	Pag ment tant: jury c		* 4 □ Donation 5 □ Other (Specify)			emet	Heaven Ferv	-	20	004	Silver		ng, MD
Baltimore,	permit. Pages: Department of H Important: If ite any injury or of		21. Signature of Funeral Service Ocean	10-		F: 50	Name and Address rancis J. 00 Univer	ss of Facility Coll sity	ins Blvd	Funeral	Home ilver	Inc. Sprin	g, MD 20901
10.00			23a. Part / Enter the disease, or combi shock, or heart failure. List only or	ications that caused t ne cause on each line	he death. Do r).	not ente	r the mode of dyin	g, such as c	ardiac oi	r respiratory arre	est,		Approximate Interval Between
į.	Physician	į	Immediate Cause (Final disease or condition	a. H	ypoxia								Onset and Death
4	/Medical Examiner		resulting in death)	Due to (or as a			/ / /		,				
		-	Sequentially list conditions if any, leading to immediate	Due to (or as a			tructure L	ungo	125-10	3-gholina			23 924
	nted I ansit	E E	cause. Enter Underlying Cause (Disease or injury		7	,-							
Ć.	icate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence	of):							
8760,	te be ysicia ne bur	dlcal	L.	d									
9	nd ph ng ph as th	Medi	IF FEMALE:									1	
.O. Box	that the death certifi ed by the attending detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	☐ Fetal death		Ectopic pregnancy Other (specify)		_			ate of delive onth	ery Day Year
<u>a</u>	res that igned b be deta	by Pi	Part II. Other significent conditions con		_	the un	derlying cause give	en in Part I.		23e. Did tob	acco use con	tribute to t	ne cause of death?
ğ	v require been sig should b		Corcho	morposte	1.					1 □ Ye	s 2 No	3 🗌 Prot	pably 4 ⊠Unknown
Division of Vital Records,	e las has je 2	Completed								24a. Was ar autops perform	ned?	Were auto prior to co death? 1 \(\sum \) Yes	psy findings available mpletion of cause of
ita		a	25. Was case referred to medical					26. Place of	of Death	1 ☐ Yes 2 Check onl on	22	103	20110
<u>†</u>	S 0 5	To B	examiner? 1 □ Yes 2 \ No	fospital: 1 🔀 Inpatien	t 2□ER/Ou	tpatient	3□ DOA Othe	er: 4 🗌 Nurs	ing Hom	ne 5 🗌 Reside	nce 6 🗆 Oth	ner (Specif	(y)
D 0	ding Ph. h. After thi funeral	:uo	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day		Time of njury	28c. Injury Work	at	2	8d. Describe ho	w injury occur	red	
sio	Attending r death. ector: Alter by the funer	cati	2 Accident investigation 3 Suicide 6 Could not be					Yes 2 □ N	-				
DΙΧ	l or At after of Direc	Certification:	4 Homicide determined	28e. Place of Injur building, etc.	y - At home, fa (Specify)	rm, stre	et, factory, office		2	Bt. Location (St. City or Town		ber or Rura	l Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ledical C	29a. Certifier 1	sicien: To the best of ner: On the basis of e and manner state	my knowledge examination and	dor inv	occurred at the timestigation, in my op	e, date and pinion, death	place, a occurre	nd due to the ca	use(s) and mate and place,	anner as s and due to	tated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier				29c. License	number		29	d. Date signe	d (Month,	Day, Year)
			102/gr				200	0601	168		JANU,	ARY/	7 h /2004
	10		30. Name and address of person who co	mpleted cause of dea		Туре, Б	Print)	Sulu	160	n Hos	pita	1	Day, Year) 7 2004
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar		,	-	, , , , , , , , ,	- 25 (9)	11	,		
	Registr		JAN 09 2004	Seem	0	1	parker						

Schneider, Anne

			1 - For State Registrar	State of I	Marylan		artmen rtificat					giene Reg. No	Z 111111	01661
	Physici	an	1. Decedent's Name (First, Middle,	Last)							2. Date of Dea	ath Da	y Year	3. Time of Death
,	/Medic		Theresa Fran								Januar	y 5,	2004	9:40 P M
	Examin	er	4a. Facility Name (If not institution,		er)				Location of				County of Death	
			Holy Cross E		Age (In yrs. i	last hidhday	If Under		Spri	_	9 Date of Rint		Montgome	
	Funeral Director		579-40-9990	1□M 2⊠F	73	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da Feb. 24	y, Year,	O30 Mars	place (State or Foreign Intry) 1and
	0		Usual Residence of Decedent								100. 24	, 1	750 Har	, Tanu
	show	_	10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	Ba-f:	50		gomery	Si	lver S								1 □ Yes 2 🖺 No
	a or 2	吉	10e. Street and Number	D1 1 II	#710		10f. Zip					10g. Ci	tizen of What Cou	ntry?
-	ns 23	Funeral Directo	1131 University 11 Marital Status	BLVd. W.,		S 13 1		902	spanic Orig	gin? (Spe	cify Vee or No.		USA 14. Race - Ameri	can Indian
	ritan	Fun	1 X Never Married 2 Marrie	Armed Force	s?	'				i, Puerto	ecify Yes or No- Rican, etc.)		Black, White	
ğ	eli,o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	ıs:		1□Yes :	2⊠ No	Specify:			1	Specify: Whi	te
5-0	De lied within 72 nouts after death with the Maryland kiel Hygiene. Ad other then "naturel", or items 23a or 28a-f show event, the Madical Examinar must be notified at event, the Madical Examinar must be notified.	Completed	15. Decedent' (Specify only highest			16a. Deced	kind of wor	k done d	urina mosi	t of worki	na	16b. K	(ind of Business/Ir	ndustry
2	han.	mpi	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT us	e retired))					
7	Tygie Tygie Ther t nt, In	ပ္ပ	12 17. Father's Name (First, Middle, L	ast)		Legal	L Seci	retai	-	r's Name	(First, Middle,		Law	
an	d ba	To Be	John B. Schrid								Lynch	Maider	(Jumame)	
<u></u>	should and Men s marke umatic	ř	19a. Informant's Name/Relationsh			19b. Mailin	ng Address	(Street a				r, City	or Town, State, Zij	o Code)
Ž	and 2 ealth a n 27 is		Alfred M. Schri	der/Brothe	r	8372	Resea	voi	Roa	d, F	ulton,	MD :	20759	
J.	- I 5 5		20a. Method of Disposition 1 Burial 2 □ Cremation	2 Dameural from Cta	20b. P	lace of Dispo emetery, cren te of	sition (Nan	ne of ther place	9) -		ary 9	20c. L	ocation - City or T	own, State
Ĕ	ment of ury or o		'4 □Donation 5 □ Other (Sp.		Ga.	Cemet	неаve ery	n			004	Sil	ver Spri	ng, MD
Baltimore, Maryland 21215-0036	permit. rages Department of Importent: If it eny injury or one.		21. Signature of Funeral Service L	icensee		F r	. Name an	d Addres	s of Facility Colli	ns I	Tuneral	Hom	e Inc.	***************************************
E	hysician /Medical Examiner	niner	23a. Part1. Enter the disease, or of shock, or heart failure. List of the shock or heart failure. List of the shock of the	a. Pneumo Due to (or B. Sacra	n line. Onia as a consequ l Decul as a consequ	uence of):		e of dying	g, such as	cardiac o	r respiratory an	rest,		Approximate Interval Between Onset and Death
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O. Box	inal the death certification by the attending phy detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		1 2 ☐ Fetal t at time of de	death 3	Ectopic pro Other (spe						23d. Date of delive Month	ery Day Year
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I Kec	ate has b page 2 sl	Completed							-		24a. Was a autop: perfor	sy med?	prior to co death?	psy findings available mpletion of cause of
N 1	this certificateral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			-				(Check only or			
_ }	ath. r: After this e funeral di	atlon: To	1 ☼ Yes 2 ☐ No 27. Manner of Death 1 ॐNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of li (Month,	atient 2 □ I njury Da <i>y Year)</i>	ER/Outpatien 28b. Time of Injury		Bc. Injury Work	' 4 □ Nur at ? es 2 □ N	2	ne 5 Resid 8d. Describe h		6 □Other (Specify occurred	y)
DIVISION	to the troughted or Attending the within 24 hours after death. To the Funerel Directors After the completely filled in by the funeral	Certification;	3 Suicide 6 Could no 4 Homicide determin	ed 286. Place of	Injury - At ho etc. (Specify	me, farm, stre	eet, factory	office		2	8f. Location (S. City or Town	treet an n, State	d Number or Rura)	d Route Number,
11000	in 24 hou the Fune pletely fil	ledical	(Check only 2 Medical E	Physician: To the be xaminer: On the basis and manner	s of examinat	wledge, death ion and/or inv	estigation,	in my opi	inion, deat	d place, a h occurre	ed at the time, d	late and	d place, and due to	the cause(s)
		Σ	29b. Signature and title of certifier				29c.	License			2		te signed (Month,	*
•	3		Myla		NNIE,			D60)619			Jar	nuary 6,	2004
	- 4		30. Name and address of person w					ad c	liktor	Cn-	ing MD	201	010	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 9 2	32. B egi	strar's Signat			u, s		apr	ing, MD	20	710	

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Year Harry Shandelson 2004 /Medical January 4:00 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01nev Montgomery If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Days 1QM 2□F 359-10-5107 Director 89 Feb 2, 1914 Illinois Usual Residence of Decedent 10a. State 23a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐Yes 2 ☐ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3005 S. Leisure World Blvd., #626 20906 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? "natural", or Itams 14. Race - Americen Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces:

1 Yes 2 No
If Yes, Give
Year or Dates: WW] T filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No þ 3 Widowed 4 Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Deputy Regional Commissioner Social Security Admin. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) mit. Pages 1 and 2 should be fill pertiment of Health and Mental High creats: If item 27 is marked out y njury of other traumatic even Benjamin Shandelson Efrod 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code), 19906 19a. Informant's Name/Relationship (Type, Print) Ruth Shandelson, 3005 S. Leisure World Blvd, #626 Silver Spring, MD wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
'4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Garden 1/7/04 Olney, Maryland any nj 21. Signature of Funeral Service 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels, Inc. Donald (1170 Rockville Pike, Rockville, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Seizure 1 hour /Medical Due to (or as a consequence of): Examiner History of Meningioma 9 years Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and e burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical phys. attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Year Day 5 Other (specify) ed by the a detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Coronary Artery Disease page 2 should Be Completed 1 Yes 2 1 No 3 Probably 4 Unknown Hypertension 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2 A No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 🔀 No 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 X Natural 5 Pending 24 hours after death.

Funaral Director: A 2 Accident investigation 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) To the within 2 To the 29b. Signature and title of ertifie 29c. License number 29d. Date signed (Month, Day, Year) U - m D500612 8 January 5, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samuel Maller, M.D. 3305 N. Leisure World Blvd., Silver Spring, MD 20906 31. Date filed (Month, Day, Year) State 32. Registrar's Signature souks Registrar JAN 0 7 2004

			1 - For Stete Registrar	State of Mary		artment c				giene Reg. No. 200	4 01663
	Physici	an	Decedent's Name (First, Middle, Last,)					Date of Dea Month	ith Day Yea	3. Time of Death
1	/Medic Examir	al	Se1ma Sma11 4a. Facility Name (If not institution, give	street and number)		4b. City, Tov	vn, or Location		anuary	7 2004 4c. County of De	8:00 A ^M
	Funeral Director		817 Quince Orchard 5. Social Security Number 6. Sec 096-12-2415 1D	x 7. Age (In	yrs. last birthday) 0 Yrs.	If Under 1 Y	thersbu ear If Under ays Hours	r 24 Hrs.	8. Date of Birth June 30	Montgo 1923 N	omery irthplace (State or Foreign Country) ew York
	Aaryland F show	or	Usuel Residence of Decedent 10a. State 10b. County MD Montgome		Caith	ocation nersbur	<u> </u>				10d. Inside City Limits 1 ☐ Yes 2)∑No
	h with the h	Funeral Director	10e. Street and Number 817 Quince Orchar		Garti	10f. Zip Co	de	878	į	Og. Citizen of What	-
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28s-f show amounts: If item 27 is marked other than "natural", or Items 23a or 28s-f show any injury or other traumatic event, Its Madical Examinate must be multiled at once.	by	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	Was Decedent If Yes, specify (city Yes or No- lican, etc.)		nerican Indian, nite, etc.
215-0	hin 72 ho s. in "natur Mudical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		16a. Deced (Give life.	dent's Usual O kind of work d DO NOT use re	ccupation one during mos etired)	st of workin	g	16b. Kind of Busines	ss/Industry
Maryland 21215-0036	illed with Hygiene other tha	Be Com	12 17. Father's Name (First, Middle, Last)		Bank	Teller		er's Name	(First, Middle,	Banking Maiden Sumame)	
rylan	hould be d Mental narked on natic ev	To B	Hyman Kislewitz 19a Informant's Name/Relationship (T)	una Print)	10h Mailie	na Address (CA		e Levy		City of Town Order	To Oa day
, Ma	and 2 sl ealth an m 27 Is r ner traur		Michael Small (So	n)	17 Na	ative D	ancer (Ct. Ga	aithers	r, City or Town, State burg, Md.	20878
Baltimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ☐ Burial 2 (X) Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	b. Place of Dispo cemetery, crem Metropol:	natory or other	place)	Jan. 200	8,	20c. Location - City o Alexandria	or Town, State , Virginia
Balti	permit. Departrimports any inju		21. Signature of Funeral Service Licens	Jan		Name and A		^{ity} De	Vol Fur	neral Home urg, MD 20	, 10 East 877
,	Priysician /Medical Examiner		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ication that caused the ne cause on each line. a. Cerebral V Due to (or as a core.)	death. Do not ent	er the mode of	dying, such as				Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	ilcal Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease of injury	Due to (or as a cor Due to (or as a cor							Address of the second s
P.O. Box 6	Attending Physicien: The law requires that the death certificate be executed refeath. redeath. sctor: After this certificate has been signed by the attending physician and be the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	3c. If yes, outcome of pri 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3 ☐]Ectopic pregna] Other (specify				23d. Date of d Month	elivery Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions con Coronary Artery D		resulting in the u	nderlying cause	given in Part	I.			to the cause of death? Probably 4 □Unknown
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₹	siciel certif recto	Be	25. Was case referred to medical examiner?	lospital:					(Check only on		
on of	ling Phys After this uneral di	lon: To	27. Manner of Death 1 🖾 Natural 5 🗆 Pending	28a. Date of Injury (Month, Day Yea	2 ER/Outpatien 28b. Time of Injury	28c.	Injury at- Work?	28		ence 6 Other (Sp ow injury occurred	ecify)
Divisio		Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp.	At home, farm, streecify)		1 □ Yes 2 □	-	3f. Location (St City or Town	reet and Number or F n, State)	Rural Route Number,
	To the Hospital or within 24 hours afte To the Funerel Dir completely filled in	Medical (29a. Certifier 1 Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier (Check only one)	sicien: To the best of my ner: On the basis of exar and manner stated.	knowledge, death nination and/or inv	occurred at the	ne time, date ar my opinion, dea	nd place, an	nd due to the ca	ause(s) and manner a ate and place, and du	as stated. se to the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier	2.0			cense number		2	9d. Date signed (Mor	
7	6		30. Name and address of person who co	empfeted cause of death iner M.D. 60		Print)	2650 1vd . #3	300 Pa	okvi11	January 8	
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registrar's S		Spar		- RO	CKVIII	-, riu. 200	J

			1 - For State Registrar	State	e of Ma	arylan		artment of H		and M		giene Reg. No.	200	L	01664
			Decedent's Name (First, Middle	e, Last)							2. Date of De	ath		·	3. Time of Death
	Physici /Medio		Helle Starcke								Month Januar	Day	2004	ar	12:53A M
	Examir		4a. Facility Name (If not institution	n, give street an	d number)			4b. City, Town, or	r Location o	of Death			County of [Death	
			Suburban Hospit	al				Bethesda				Mo	ntgom	ery	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🔀		(In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	y, Year)		Birthpla Countr	ce (State or Foreign
	Director		052-28-3818 Usual Residence of Decedent			74_	TIS.				June 14	, 192	29 D	enma	rk
	land ow		10a. State 10b. County			10c. City	, Town or Lo	cation						10	d. Inside City Limits
	Many International	ţ	Maryland Montgo	merv		Roc	kville								1 ☐ Yes 2 No
	r 28g	Director	10e. Street and Number	,		1100		10f. Zip Code				10g. Citiz	zen of Wha	t Countr	y?
	th wit	a D	12732 Veirs Mi	ll Road	#103			20853				Unit	ed St	ates	
	ems ems	Funeral	11. Maritat Status	12. Was	Decedent 6 d Forces?	Ever in U.	S. 13. \	Vas Decedent of H	ispanic Orig	gin? (Spe	ecify Yes or No)- 1	14. Race - A		
36	or it	y.F.	1 Never Married 2 Mar	ried 1 🗀 `	res 2∭TN s,Give	lo		∏Yes 2∭ No	Specify:		,		Specify:		
Ö	within 72 hours after death with the Maryland one. than "natural", or items 23a or 28a-f show than "natural Examinar mast be notified at	d by	3 ☐ Widowed 4 ☐ Divorced		or Dates:		16a Dassa	landa Haral Ossus	-11						
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0	Hyg other	e C	17. Father's Name (First, Middle,	Last)			110410	ar Bircom			(First, Middle,			Lan	Institute
au	lenta fenta rked ic ev	To B	Gustav Starcke						Gudru	un St	randho	1m			
Maryland 21215-0036	and A s ma	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	g Address (Street a	and Numbe	r or Rura	I Route Numbe	er, City or	Town, Sta	te, Zip C	ode)
Σ	and 2 valth i		Bente King/Sist	er			8 Hil	1crest Ro	oad, 1	Itha	ca, New	Yor	k 148.	50	
ore	of He fiten		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation	3 DRamoval f	rom State	20b. P	lace of Dispo emetery, cren	sition (Name of natory or other plac Y	εθ) J	anua	ry 4,	20c. Loc	cation - City	or Tow	n, State
Ĕ	Par in a par		`4 □Donation 5 □ Other (S		TOTTI OTATO	Cre	mātori	um, Inc.		2002		Beth	esda,	Mai	yland
Baltimore,	permil. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or flems 23a or 28e-f show amportant: in item 27 is marked other than "natural; or flems 23a or 28e-f show ampoint injury or other traumatic event, the Medical Examiner mast be notified at once.		21. Signature of Funeral Service	Licensee		101	Ro Ro	Name and Address	ss of Facility	yRobe 300	ert A. West M	Pumpl	rey	Fune Ave	ral Home/ nue
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8760,	Attending Physician: The law requires that the death certificate be executed rideath. ector: After this entiticate has —en signed by the attending physician and by the funeral director, page 2 should be deteched for use as the burial-transity for the funeral director, page 2 should be deteched for use as the burial-transity.	dlcai		d											
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<u></u>	R. H. B.	ate	1. Natural 5 ☐ Pendir 2 ☐ Accident investi	.3	Month, Day	rear)	Injury		k? Yes 2.⊟h	No					
Division of	l or Attending after death. Director: After in by the funer	ertification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 200. h	Place of Inju	ry - At ho	me, farm, stre	eet, factory, office		- 1	28f. Location (S City or Tox		Number o	Rural F	Route Number,
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	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	100	(Check only 2 Medical	Examiner: On t	he basis of	examinat	wledge, death	occurred at the timestigation, in my op	ne, date and pinion, deat	d place, a	and due to the	cause(s) a	and manne place, and	as stat	ed. ne cause(s)
	To the H within 24 To the F complete	Medic	one) 29b. Signature and title of certifie	and	manner sta	ted.		20- 1				001 0.1	4 /4		
	Z <u>₹ ₹ 8 9</u> (1	Supractive and title of certifie	~ ~	ule-	m	0	MD	D564	139		OI	signed (M	onin, De Mal	y, (ea)
-	1 7	1	20 Name and address of a sure	who completed	anuac of d	- 4 1 t t	22a) (T:	Dui-e)			1	01 1	0410		
	1	1	30. Name and address of person	Turbo		9901	Me a	Print) Rical Can	iter D	nk,	Rocky	ille,	MO	208	S
	Sta	ate	31. Date filed (Month, Day, Year)	0003	32. Hagistra			,	tel non		-				
	Danie.		IAMAE	71HF#	7 May	sec.	M	1 1							

		1 - For State Registrar	State of Marylar		ate of Death	Reg.	_	Uibb
hysicia	an	Decedent's Name (First, Middle, I		1.1		Date of Death Month	Day Year	3. Time of Death
/Medic	al		Nell P. Stova			January	7, 2004	2:00 F
Examin	er	4a. Facility Name (If not institution, g		4b. C	ity, Town, or Location of De Rockville	eath	4c. County of Death	
moral		Rockville Nursin 5. Social Security Number 6.	Sex 7. Age (In yrs.		der 1 Year If Under 24 F	Hrs. 8. Date of Birth	Montgome 9. Birth	
neral rector		267-32-2106 Usual Residence of Decedent	1□M 2☑F 79	Yrs. Month	hs Days Hours M	Hrs. 8. Date of Birth (Month, Day, Year) April 11,	1924 F10	place (State or Fore intry) orida
Mo to		10a. State 10b. County	10c. Cit	ty, Town or Location				10d. Inside City Lim
E D	ţo	Maryland Montgon	nery	Silver Spi	ing			1 ☐ Yes 21🗓
23a or 28a-f show ust be notified at	Funeral Director	10e. Street and Number			Zip Code	10g.	Citizen of What Cou	intry?
238	al D	14628 Kelmscot	Drive		20906		United Sta	ates
r items	nei	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. Was De If Yes, s	cedent of Hispanic Origin? specify Cuban, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)	14. Race - Amer Black, White	
	by Fi	1 Never Married 2K Married 3 Widowed 4 Divorced	If Yes, Give		s 2√ No Specify:		Specify: Wh	
natural,		15. Decedent's	Year or Dates:	16a. Decedent's U	sual Occupation	161	. Kind of Business/li	
n n	plet	(Specify only highest g	rade completed)	(Give kind of life. DO NO	work done during most of v T use retired)	working	. King of Businessyn	idustry
65	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 4	Business	Office Manag	ger	Printir	ng
vent,	Bec	17. Father's Name (First, Middle, La.	st)			Name (First, Middle, Mai		
rked tic e	10	George Dewey Pi	nholster		Delah	Bielling		
item 27 is marked other than "natural", o other traumatic event, ins Modical Exa		19a. Informant's Name/Relationship	* * .	1	ess (Street and Number or		-	
m 27	. 23	Jerome D. Stoval			1mscot Drive			
F ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		Place of Disposition (I cemetery, crematory of		uarv 12.	. Location - City or T	
injury or	Ю	`4 □ Donation 5 □ Other (Spec	city) Par	klawn Memo	orial Park	2004 Ro	ckville, N	
Important: If item 27 is sny injury or other tra QDCs6		21. Signature of Funeral Service Lic	ensee M001	.98 Rober	and Address of Facility t A. Pumphres st Montgomery	y Funeral H	ome/Rockv:	ille, Inc
ed by the attending physician and consideration of the consideration of	cai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undersyling Cause (Disease or injury that initiated events resulting in death) Last	a. Atrial Fib Due to (or as a conseq b. Congestive Due to (or as a conseq c. Septicemia Due to (or as a conseq d.	uence of): Heart Fa: uence of):	ilure			
as th								
y the attendin	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of d 9□ Unknown	I death 3 Ectopic	pregnancy (specify)		23d. Date of deliv Month	ery Day Year
should be deta	by PI	Part II. Other significant conditions	contributing to death but not res	ulting in the underlyin	g cause given in Part I.		co use contribute to t	
lnous	etec					-		
ate has page 2	Completed by					24a. Was an autopsy performed 1 Yes 2X	? prior to co	opsy findings availa empletion of cause 2 No
€ 5	Be	25. Was case referred to medical examiner?				eath (Check only one)		
S ig	၉	1 ☐ Yes 2 ☒ No		ER/Outpatient 3		Home 5 ☐ Residence	6 □Other (Specia	(y)
After	lon:	27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	njury occurred	
To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be Ope Blace of lainer At he	ome, farm, street, fact	1 ☐ Yes 2 ☐ No ory, office	28f. Location (Street City or Town, St	and Number or Rura ate)	al Route Number,
2 €	Medical C	29a. Certifier 1 Certifying F	Physician: To the best of my kno iminer: On the basis of examina and manner stated.	wledge, death occurre tion and/or investigati	ed at the time, date and pla on, in my opinion, death oc	ice, and due to the cause courred at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
e Fun etely	40				29c. License number	29d.	Date signed (Month,	Day, Year)
o the Fun ompletely	₩.	29b. Signature and title of certifier	_					
	Me		10 V. Posep	4.	D47330		anuary 8	2004
To the Fun completely	Me	29b. Signature and title of certifier Wo www 30. Name and address of person who	(D47330	J	anuary 8,	2004

			1 - For State Registrar	State of Ma	aryland		artment rtificate					giene Reg. No.	200)4	0 !	566
not	Physici		1. Decedent's Name (First, Middle, La	elyn	Tay:	lor					2. Date of Dea Month	ith Day		ear	3. Time	м
	/Medio Examin		4a. Fecility Name (If not institution, giv					Town, or IBER	Location of		IANUAKI		County of	Death	10:3)_A
4	Funeral Director		5. Social Security Number 2.15-16-4086 Usual Residence of Oecedent	ex 7. Age □ M 2 14 F	o (In yrs. la	ast birthday) 4 Yrs.	If Under	1 Year Days	If Under Hours	Min.	B. Date of Birth (Month, Day June	, Year)		Count	ece (State try) ryla:	or Foreign nd
	ms 23a or 28a-f show	Director	Md 10b. County Alle	gany	10c. City	Bart										City Limits
1	23a or 2		10e. Street and Number 23107 Rainbow	Lane			10f. Zip (_	1521				ted		•	
	ini re mans and destribution maryal an "naturel", or Itama 23a or 28a-1 show Mautical Examinat must be mulified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent B Armed Forces? 1 Tyes 2 Th If Yes, Give A Year or Dates:		1	Was Decede f Yes, speci 1 ☐ Yes 2	fy Cuba	spanic Ori n, Mexican Specify:	n, Puerto Ri	ify Yes or No- ican, etc.)		4. Race -		an Indian, etc.	
9200-61212	ene. than "nature	Completed	15. Decedent's E. (Specify only highest grade Elementary/Secondary (0-12)		+)	(Give life. l	dent's Usual kind of work DO NOT use	k done d e retired,	urina mos	t of working	7		nd of Busi		,	
	tal Hygi d other event, I	Be	Unknown 17. Father's Name (First, Middle, Last, John Green			La	borer				First, Middle,	Maiden		Fib	oer I	Ind.
2	h and M	To	19a. Informant's Name/Relationship (Vickie Harvey/I						nd Numbe	or or Rural I	Route Numberton, M	r, City or			Code)	
Baltimore,	E 48 3		20a. Method of Disposition 1 ∑Naurial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specif		Ce	ace of Dispo emetery, cren JREL	sition (Name natory or oth Hill	e of her place Cen	a)	Dai 1 / 7 / 0	te) 4	20c. Lo	COW	ty or Tov , Mđ	wn, State	
Rail	Depart Import any inj once.		21. Signature of Funeral Service Licer	re Bor	l	W	ester	rnpc	rt,	ч d. ∠	,111 21562		rch	st		
E	hysician and business and the parial-transit	cal Examiner	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or a) Due to (or	e. RIGI	HT MID sence of):					espiratory are	est,			Approxima Interval Be Onset and WEEK	tween Death
ords, P.O. Box 68/60,	by the attending physiached for use as the	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ₱ No 9 ☐ Unknown	23c. If yes, outcome of the composition of the comp	2 🗌 Fetal	death 3 [Ectopic pre					2	3d. Date o		,	Year
ecords, P	been signed b should be deta	by	Part II. Other significant conditions of	ontributing to death bu	it not resul	Iting in the ur	nderlying car	use give	n in Part I.		23e. Did to	bacco us			e cause of	
I Hec	ate has b	Completed						 			24a. Was a autops perform	V	24b. We prio dea 1 []	re autoporto com th? Yes 2	sy findings pletion of	available cause of
or vital	is certificate director, pag	ro Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 15 Inpatier	nt 2 🗆 8	ER/Outpatien	t 3 DOA	Othe			Check only on 5 ☐ Reside	-/-	□Other ((Specify)		
	fler	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b			28b. Time of Injury	М			286 No	d. Describe ho	ow injury	occurred			nhor
אוט אַנ	within 24 hours after death. To the Funerel Director: A completely filled in by the funerel fil		4 Homicide determined 29a. Certifier 1 Certifying Ph	building, etc	. (Specity))			e, date and	No. Wash	City or Town	n, State)				noer,
the Ho	thin 24 h	Medical	(Check only one) 2 Medicel Exemple one) 29b. Signature and title of certifier	niner: On the basis of and manner sta	examinati	ion and/or inv	estigation, i	in my op	inion, deat	th occurred	at the time, d	ate and	place, and signed (A	I due to t	the cause(s)
Ļ	3 7 8		Morkerstan	Same 4	ath (Item	23a) (Tyne	D1	1486			i i		RY &			
	Sta	ite	DR.ROBUSTIANO BAR 31. Date filed (Month, Day, Year)		EMORI	[AL AV	•	STE	201	CUMBE	ERLAND,	MARY	LAND	215	02	

			For State Registrar	State of M	arylan		artment rtificate				lenta	-	iene	004	01667
			Decedent's Name (First, Middle, L	ast)								e of Deat	h		3. Time of Death
н	Physici		Tou lie The	odore	Th	owas					Мо	nth 1	Day	Year O U	200 AM
	/Medio Examir		4a. Facility Name (If not institution, g		-	04-65	4b. City, 7	Town, or	Location of	of Death				inty of Death	
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	Funeral		5. Social Security Number 6.			last birthday)	If Under		If Under		8. Dat	of Birth			lace (State or Foreign stry)
	Director		172-28-0195	1 X) M 2□F	68	Yrs.	Months	Days	Hours	Min.		nth, Day,		Maryl	
			Usual Residence of Decedent				ll.				rug.	12/	1705	FIGLYI	and
	ylan		10a, State 10b. County		10c. Cit	ty, Town or Lo	cation							1	0d. Inside City Limits
	Mar Hed	ţo	MD Garrett	:	Frie	endsvi:	lle								1 □ Yes 2 No
	hours after death with the Maryland tural; or items 23a or 28a-1 show at Examinar must be multiled at	Director	10e. Street and Number				10f. Zip	Code				10	g. Citizen	of What Cour	ntry?
	3a o		204 77 1						21531					~ ~	
	Jeath Jeath	Funeral	284 Humberson Ro	12. Was Decedent	Ever in U	.S. 13.	Was Decede			gin? (Spe	ecify Ye	s or No-	14. F	Race - Americ	an Indian,
رم	fter of the control o	Ē	1 ☐ Never Married 2 🔀 Married	Armed Forces	No.	ì		**		i, Puerto	Rican,	etc.)	E	Black, White,	etc.
g	o','e	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2	No No	Specify:	,			Spe	cify:	White
ŏ	72 hours natural', lical Ex	ed	15. Decedent's I	Education		16a. Dece	dent's Usual	I Occupa	ition				16b. Kind o	f Business/Inc	
7.	n "nat	Completed	(Specify only highest g		5.)	(Give	kind of worl DO NOT use	k done d e retired,	lu <i>ring</i> mosi)	t of worki	ng				
72	within iene.	E	Elementary/Secondary (0-12)	College (1-4or	D+)	Owner,	Opera	ator					Used	Car/Re	etail
b	be filed tal Hygi d othar	a l	17. Father's Name (First, Middle, Las	it)			-		18. Mothe	er's Name	(First,	Middle, A	faiden Surr		
an		ToB		-1							_	, .			
7	≾ ≥ 5 5	1	George Kenneth 7 19a. Informant's Name/Relationship			19b. Mailir	na Address	(Street a				sbrir		wn, State, Zip	Code)
Maryland 21215-0036	d that														
	ges 1 and It of Health If itam 27 or other t		Mary K. Thomas/V	viie	20b. P	Place of Dispo	Humber		Road		ieno			AD 215 on - City or To	
ğ	Pages nent of I int: If its iry or o		1 X Burial 2 ☐ Cremation 3		C	emetery, crer	natory or oti	her place	.						
₫	tmer tant tant		`4 □Donation 5 □ Other (Spec		San	d Spri							riend	dsville	e, MD
Baltimore,	permit. Page Department of Important: If any injury of once.		21. Signature of Funeral Service Lice	ensee		No.	Name and	Fun	s of Facilit era I	Home	s,	P.A.			
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н			23a. Part1. Enter the disease, or con shock, or heart failure. List onl	mplications that cause y one cause on each l	d the deatl ine.	h. Do not ent	er the mode	of dying	g, such as	cardiac c	r respir	atory arre	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	5 . 1		tage	C.		(10:	1.6	10-	the	4		Onset and Death
	/Medical		resulting in death)	a. Due to (or as	a conseq	uence of):	CCC	V 6	(101	1	pe	1.1	1		July
	Examiner			Co	00	avy	CIV	ter	4	di	50	c (12		
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	uted d ansit	Examiner	Cause (Disease or injury that initiated events												
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×	leath certific attending p I for use as I	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregna	incy							234 1	Date of delive	0/
Вох	atter for u	jar	23b. Was decedent pregnant in the past 12 months?	1⊡Live birth 4⊡Pregnant a	2 Feta	Ideath 3□	Ectopic pre Other (spe	gnancy							Day Year
o.	at the de by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	t time or di		Other (ape								
σ.	that the		Part II. Other significant conditions	contributing to death h	out not resi	ulting in the u	nderlying ca	iliea aiva	n in Part I		236	Did tob	acco use co	antribute to th	e cause of death?
JS,	se us ed	by	CHE CLO	CCTV		annig in the di	noonying ou	.030 g.+6	a				s 2□No		1.5
Ö	w requir been si should	tec	2)	33 14	0 =	_	20								
Division of Vital Records,	aw Is b	ompleted	Chroni	· Vanu	义,	LVISI	Me	تعلى	me	<u></u>	248	. Was an		 b. Were autor prior to con 	psy findings available inpletion of cause of
<u> </u>	T age	Son	CVA				0 4	h.	0	7	10	perform Yes 2	ed? No	death? 1 ☐ Yes	2 □ No
ita	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical						26. Place	of Death	(Check				
>	S S	10 E	examiner? 1 ☐ Yes 2 /2 No	Hospital: 1 ☐ Inpatio	ent 2	ER/Outpatien	t 3 DOA	A Othe	r: 4 □ Nu	rsing Hor	ne 5	Aeside	nce 6 🗆 C	Other (Specify)
0	ding Phy th. After thi funeral		27. Manner of Death	28a. Date of Inju (Month, Da	iry Vear)	28b. Time of	28	c. Injury Work	at	2	28d. De	scribe ho	w injury occ	urred	
<u>o</u>	Attanding r death. ector: After by the fune	atlo	1 → Natural 5 Pending 2 Accident investigation		y / ou/	ii ijui y	М		: ′es 2 🗆 1	No					
<u> </u>	or Attano after deatl Director: in by the	iţic	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 286. Place of in	ury - At ho	me, farm, str	eet, factory,	office		2				m <i>ber</i> o <i>r R</i> urai	Route Number,
ā	after Dire	Certification;	4 Homicide	building, ef	с. (<i>Specii</i>)	Y)					City	or Town,	State)		
	To tha Hospital or At within 24 hours after o To the Funeral Direct completely filled in by		29a. Certifier 1 Sertifying F	hysician: To the best	of my kno	wledge, death	occurred a	t the time	e, date and	d place, a	and due	to the ca	use(s) and	manner as sta	ated.
	a Ho 24 } e Fu letely	edical	(Check only 2 Medical Example)	nminer: On the basis of and manner st	f examina	tion and/or inv	estigation,	in my op	inion, deat	th occurre	ed at the	time, da	te and plac	e, and due to	the cause(s)
	To tha within 2 To the complet	<u>B</u>	29b. Signature and title of certifier				29c.	License	number			29	d. Date sign	ned (Month, L	Day, Year)
	> F 0		Dan A		200	00		47	Call	ru			11	-10	Ú
	0		30. Name and address of person who	completed source of	toath (Item	23a) /Tuna	Print)	112	ar II	>			1 (3	1	7,00
	3		Danie and address of person who	Joseph Galage of C	Meni) maer	(1) 3 l	0000	10.0	D. T	101	00	21	16111	of in	D 51225
	Sta	•	31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ture	Le 1	1CA.	4 > F	JA. L.	ر ب	اناس	HICAN	TAN	У
	Registr		JAN O &	2004	To det	K	South.	0							

			1 - For State Registrar Amend Item#7pe	State of Mar erFHG8282/25/0		artment ertificate				-	iene	2004	0	568
	Dhusisi		1. Decedent's Name (First, Middle, Las	t)						. Date of Deat Month	Day	Year	3. Time of	
	Physici: /Medic			ARION IDA	TOBIN			 		anuary	_	2004	8:15	P M
	Examin	er	4a. Facility Name (If not institution, give		F 1			Location o	of Death			ounty of Death		
			Sunrise Assisted 5. Social Security Number 6. Se		rederica In yrs. last birthday		deri 1Year	C.K. If Under:	24 Hrs. 8	Date of Birth		ederick	place (State o	or Foreign
н	Funeral Director		050-07-2330				Days	Hours	Min. A	Date of Birth (Month, Day, ug • 22	Year) 191	14 New	ntrv)	
	D		Usual Residence of Decedent											
	show	_	10a. State 10b. County Md. Frederi		Oc. City, Town or I								10d. Inside C 1 TXTYes	ıty Limits 2 □ No
	the M	ectc	10e. Street and Number			10f. Zip	Code			1	On. Citize	n of What Cou		
	within 72 hours after death with the Maryland ene. than "natural", or tlems 23e or 28e-f show the Modical Examinat must be molified at	Funeral Director	990 Waterford Dri	ve			2170	2			-	S.A.	,.	
	death ms 2;	nera.	11. Marital Status	12. Was Decedent Eve	er in U.S. 13	. Was Deced	lent of Hi	spanic Orig	gin? (Specif	y Yes or No- can, etc.)	14	. Race - Ameri		
9	or Ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2		Specify:		AII, etc.,	S	Black, White, pecify: Wh:		
21215-0036	ural',	d by	3 XWidowed 4 □ Divorced	Year or Dates:	100 Dec									
75	in 72 i	lete	15. Decedent's Ed (Specify only highest grad	de completed)	(Giv	edent's Usua re kind of wor OO NOT us	rk done d se retired,	ition fu <i>ring m</i> ost)	t of working		16b. Kind	of Business/In	idustry	
212	yiene.	Completed	Elementary/Secondary (0-12)	3 Years +	Home	emaker						None		
פּי	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than 'natural', or liems 23a or 28a-1 show aumatic event, the Macifiel Examinar must be notified at	BeC	17. Father's Name (First, Middle, Last)							First, Middle, I				
Maryland	should be and Mental I marked o	인	George Beck						elena		knowi			
Nar	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (7									own, State, Zij	_	
	s 1 and of Health item 27 other tr		Mr. Ronald G. Tob 20a. Method of Disposition	oin (Son)	20b. Place of Dist	24 Bevenosition (Name	ne of	1	Dat	-		d. 2170		
ē			1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		cemetery, cr Knolls	ematory or ot	ther place	1	L-07 - 0	165		Washing		Υ.
Baltimore,	교원관금 .		21. Signature of Funeral Service Licen		1	22. Name and	d Addres	s of Facilit	Ψ _z ε α)	ID A T	HOVES	- ·	
B	Depa Impo any i		Nobest Co	Salley		201 NC	DRTH	MARK	Y & SC ET ST	, FREI	ERAL	HOMES, K, MD	P.A. 21701	
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	Physician		Immediate Cause (Final disease or condition		ge Osteoj								Onset and I Years	
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):									
	_xaiiiiioi	5	Sequentially list conditions,	b. Restriv	tive Lung	g Dise	ase						Years	
	uted insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		s Mellit	us Type	e II						Years	
Ċ,	sician and burial-transit	Еха	resulting in death) Last	C	consequence of):									
68760,	a y a	cal		d. <u>Periphe</u>	ral Vasc	ular D	isea	se					Years	
	death certifica attending ph d for use as th	Physician/Med	IF FEMALE:	00 · W · · · · · · · · · · · · · · ·										
Box	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tin	Fetal death 3	□Ectopic pre					230	Date of deliver Month	-	Year
o.	that the de led by the a detached f	ıysıc	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	ne or death 5	□ Ottler (spe	BCIIY)							
<u>α</u>	es that igned by be deta	by Ph	Part II. Other significant conditions of	ontributing to death but	not resulting in the	underlying ca	ause give	n in Part I.		23e. Did tob	acco use	contribute to t	he cause of c	eath?
rds	quires an sign uld be	o pa	Failure to Thrive	e, Severe K	yphorsis					1 ☐ Ye	s 2 💢	No 3 ☐ Prot	oabiy 4 ⊡t	Jnknown
Records,	ie law requir has been s je 2 should	plet	Anoerxia, Cachexi	icut						24a. Was a		24b. Were auto	psy findings mpletion of c	available ause of
Ä	ding Physician: The I h. After this certificate ha funeral director, page	Completed	Immobility Syndro	ome. T						perform 1 ☐ Yes 2	ned?	death? 1 ☐ Yes		
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of	Physi this c	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death		2 ER/Outpati					5 Reside		a ☐Other (Specif	ЫІİVI	ğ
	e fe	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	(ear) Injury	M	8c. Injury Work	(?` /es 2 □!		s. Describe no	w injury c	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Division	Attending ir death. ector: After by the fune	ifica	3 Suicide 6 Could not be	28e. Place of Injury	At home, farm, s	street, factory,	, office		281			Number or Rura	al Route Num	ber,
Ę	al or saffer	Certification;	4 Homicide	building, etc.	(Specify)					City or Town	, State)			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		(Check only 2 Medical Exam	ysicien: To the best of e)
	the P the F the F	Medical	one) 29b. Signature and title of certifier	and manner state				number				signed (Month,		
	To To To To To To To To To To To To To T		Signature and the of certifier	Sille.	1 ml		4749			2.		02 200		
,	Ý		30. Name and address of person who		7									
	٦		Allen Reilly, MD	801 Tol1			te D	-1 Fr	rederi	.ck, Md	. 21	701		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	4								
	Registi	rar	JAN -	6 2004	-	1	100	acks						

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	Physici /Medic	cal	James Henry Thomas 4e. Fecility Name (If not institution, give street and number)		4b. City, Town, or	Location of	J	2. Date of Death Month January	Day 1,20		3. Time of Death
8:	Examir Funeral Director	ier	Frederick Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last bir.	thday) Yrs.		deric	k	8. Date of Birth (Month, Day,) Apr. 10	Fre	eder	
Baltimore, Maryla	d other than "naturel", or flems 23a or 28a-1 show event, the Medical Examiner must be notified at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town MD Montgomery Dam 10e. Street and Number 11805 Prices Distillery Rd 11. Maritat Status 12. Was Decedent Ever in U.S. Armed Forces? 18 Yes 2 No. 1968 - If Yes, Give Year or Dates: 1972 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) 12th 17. Father's Name (First, Middle, Last) James Williams 19a. Informant's Name/Relationship (Type, Print) Esther D. Thomas Wife 20a. Method of Disposition 1 Burial 2 Roremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral 3 rece Licensee 22a. Part I. Enter the Jisease, or complications that caused the death. Dor shock, or hear/failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of the control of the control of the control of the control of the control of the cause on each line.	Decección de la la la la la la la la la la la la la	CUS 10f. Zip Code 2087. Was Decedent of Hi If Yes, specify Cubai 1 Yes 2 No Ident's Usual Occupa kind of work done of DO NOT use retired, Denter 1 Gallac Sition (Name of natory or other place 1 Unrl. Si 2. Name and Address 3 Gallac 3 Gallac 4 N Was 1 or the mode of dying 1 or the mode of dying	spanic Origin, Mexican, Specify: ation luring most of My and Number gher ycs 1 s of Facility Shing g, such as ca	of working s Name rtl or Rural Way Da -/8/ Sn ston ardiac or	g 16 (First, Middle, Mae Thomas Route Number, COlney, ate 2004 St Rooten I St Rooten S	14. Rac Blac Specify HOME TO Town, MD C. Location - Alexan	Whet Course of State, Zipen of the Course of State, Zipen of the Course	10d. Inside City Limits 1 Yes 2 No ntry? can Indian, etc. ack dustry 2 Code)
. Box 6876U,	ig phys	Physician/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the cons	of):	Ectopic pregnancy				23d. Dat	e of deliventh	ery Day Year
cords, P.O	been signed by the attendir should be detached for use	by	9☐Unknown Part II. Other significant conditions contributing to death but not resulting in Diaheter.	the ur	nderlying cause give	on in Part I.				ibute to t	he cause of death?
The law	ate has b	e Completed	25. Was case referred to medical			00 8			d2/ 5	Vere auto prior to co leath? Yes	ppsy findings available mpletion of cause of 2 No
IVISION OF	ter death. irector: After this n by the funeral di	Certification: To Bo	examiner? 1/□ Yes 2 □ No Hospital: 1 □ Inpatient 2/□ ER/Ou 27. Manper of Death 28a. Date of Injury 28b. T	Time of njury	28c. Injury Work M 1 🗆 Y	r: 4 🗆 Nurs	sing Hom 28	(Check only one) 18 5 Residence 18 Residen	injury occurr	ed	
To standard	within 24 hours at To the Funeral D completely litted in	Medical Co	29a. Certifier (Check only one) Medical Exeminer: On the basis of examination and and manner stated. 29b. Signature and title of certifier) 30 Name and address of person who completed call the of death (Item 23a) (Ite	d/or inv	vestigation, in my op	number	occurred	d at the time, date	and place, a	ind due to	Day, Year)
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	4	Sparks	/	2,	11(()e	VICK,	MI	4 41/01

			For Stete Registrar	State of	Maryland /			of Health an of Death	nd Mental Hyg	giene Reg. No.	304	01670
			1. Decedent's Name (First, Middle, La	ist)					2. Date of Dea	ath Day	Voor	3. Time of Death
	Physici.	_	Martha	Frances	Vand	la11			Januar		Year 2004	8:00 P M
	/Medic Examin		4a. Facility Name (If not institution, gi	e street and numi			4b. City, To	wn, or Location of D			nty of Death	
			Goodwill Mennon:	ite Home			(rantsvil	le		Garre	tt
	Funeral				. Age (In yrs. last l	birthday)	If Under 1		Hrs. 8. Date of Birt Min. (Month, Day	h (Year)	9. Birth	place (State or Foreign
	Director		171-144406	1□M 2気F	92	Yrs.	Months D	ays Hours	Feb. 11	, 1911	_	nnsylvania
7	2		Usuel Residence of Decedent									
-	thow thow		10a. State 10b. County		10c. City, To	wn or La	cation					10d. Inside City Limits
-	Ra-f.s	to c	MD Ga:	rrett			Frier	dsville				12∑Yes 2 □ No
1	0.28	Director	10e. Street and Number				10f. Zip Ce	ode		10g. Citizen d	of What Cou	intry?
4	23e	-a	Friendship Heig	nts				21531			USA	
		Funeral	11. Marital Status	12. Was Deced	ent Ever in U.S.	13.	Was Decedent f Yes, specify	t of Hispanic Origin Cuban, Mexican, P	n? (Specify Yes or No- Puerto Rican, etc.)	14. R	ace - Ameri lack, White,	
ð	a P E		1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give	2 ⊠ No		1 ☐ Yes 2 🛭				oity: Wh:	ite
Š	uraf.	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dat								
<u>,</u>	"net	Completed	15. Decedent's E (Specify onfy highest gi	ducation ade completed)	16	(Give	dent's Usual (occupation Mone during most of Tetired)	f working	16b. Kind of	Business/Ir	ndustry
7	han han	Ę.	Elementary/Secondary (0-12)	College (1-	4or 5+)	1#0.				77 1 . 1	3.5	6
Z	be fled within /2 nouts after death with the Maryland tal Hygiene. Ital Hygiene. do other than "netural", or items 23e or 28e-f show event, the Medical Examiner must be notified at	ပိ	17. Father's Name (First, Middle, Las	4+			Acco	untant 18 Mother's	Name (First, Middle,			nufacture
ַ בַ	d of	Be		_		T				Walder Surri		
Maryland 21215-0036	d Mer nark	၉	unk	unk		Jor		unk	unk	- O't T		ings
<u> </u>	hand hand risun		19a. Informant's Name/Relationship						or Rural Route Numbe		20300	p Code)
ď.	l and Healt Im 2		Frank J. Vandall, 20a. Method of Disposition	son			Stone sition (Name		., Decatur	20c. Location		Own State
ō	ges toff fite or of		1 ☑ Burial 2 ☐ Cremation 3	Removal from S	cama	tery, crer	natory or othe	r place)	Date	200. LUÇATIDI	in a City of T	OWII, State
altimore,	men men tent:		`4 ☐ Donation 5 ☐ Other (Special	7.70	Thaye				/7/2004	0aklar	id. Ma	ryland
g	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of the Traumatic event, the Medical Examiner must be notified at Once.		21. Signature of Funeral Service Lice	nse				Address of Facility	Stewart			ne
	₫ Q = @ ql		Stadley 16.	Ser Com	<u> </u>				., Oakland		21550	
	hysician /Medical		23a. Part1. Enter the disease) or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on ear	used the death. Di ch line. IMONIA r as e consequence		er the mode o	of dying, such as ca	rdiac or respiratory ar	rest,	-	Approximate Interval Batween Onset and Death Weeks
	Examiner	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (o	r as a consequenc	e of):						
9/60,	cate be executed physician and the burial-transit	dical Examin	that initiated events resulting in death) Last	c	r as a consequenc	e of):						
	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ZANo 9 ☐ Unknown	1 ☐Live bir	ome of pregnancy th 2 Fetal dea nt at time of death		Ectopic preg Other (spec				Date of delived	ery Day Year
ds, r.	w requires that to be a signed by should be detailed.		Part II. Other significent conditions dementia, Alzhe			g in the u	nderlying cau	se given in Part I.				the cause of death?
Division of Vital Records,	he law reque has been age 2 shoul	Completed								sy med?	prior to co death?	opsy findings available ompletion of cause of
<u> </u>	en: tificat or, pi	O	25. Was case referred to medical					26 Place of	1 ☐ Yes Death (Check only o		1 🗆 Yes	2010
>	Physicien: r this certifica ral director, I	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 🗆 In	patient 2 ER/0	Outpatier	t 3□ DOA	0.01	ng Home 5 Resid		ther (Speci	(v)
o <i>i</i>	y Ph) or this		27. Manner of Death	28a. Date of	Injury 28b	. Time of		Injury at Work?	28d. Describe h			.,,
و	th: Afte	盲	1 XNatural 5 ☐ Pending 2 ☐ Accident investigate		, Day Year)	Injury	М	Work? 1 ☐ Yes 2 ☐ No				
DIVIS	el or Attending s after death. Il Director: After d in by the fune	Certification;	3 Suicide 6 Could not determined	200. Flace C	of Injury - At home, g, etc. <i>(Specify)</i>	farm, str	eet, factory, c	ffice	28f. Location (S City or Tow		nber or Run	al Route Number,
	To the Hospitel or Attending Physicien: The within 24 hours after death, within 24 hours after death, To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	one)	hysicien: To the t miner: On the bas and manne	pest of my knowled sis of examination or stated.	lge, deatl and/or in			place, and due to the occurred at the time, o			
i	To the within 2 To the complex	Ž	29b. Signature and title of certifier	1		1/2	29c. L	icense number		29d. Date sign		
			Marist	Run	en "	VI		D002575	9	Januar	y 4,	ZUU4
			30. Name and address of person who									
		3	Walter K. Nauman	n, M.D.,	PO Box 2	247,	Accide	ent MD 21	520			
	Sta Registr		31. Date filed (Month, Day, Year)	5 2004 Re	gisaar's Signature	K	South	U				, , , , ,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes and All Copies Are Legible.

Physician Medical Examiner As Facility Name (If not institution, give street and number) As Facility Name (If not institution, give street and number) As Facility Name (If not institution, give street and number) As City, Town, or Loc Montgomery Village Care and Rehab Center Montgomery	2. Date of Death Month January cation of Death 7. Village 8. Date of Birth (Month, Day,) June 11,	Day Year 3, 2004 4c. County of Deate Montgom 9. Birtl Co 1940 Mary g. Citizen of What Co	nery nplace (State or Foreign untry) 1 and 10d. Inside City Limits 1 □ Yes 2 🖾 No
Robert W. Vostreys, Jr. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Loc	January cation of Death 7 Village 8 Date of Birth (Month, Day,) June 11,	3, 2004 4c. County of Death e Montgom Year) 1940 Mary g. Citizen of What Co	nery nplace (State or Foreign untry) 1 and 10d. Inside City Limits 1 □ Yes 2 ☒ No
Montgomery Village Care and Rehab Center Montgomery 5. Social Security Number 6. Sex 1 1 1 1 M 2 F 6 6 7 Age (In yrs. last birthday) 1 Under 1 Year If Under 24 Hrs. Months Days Hours Min. Months Days Hours Min.	v Village 8. Date of Birth (Month, Day,) June 11,	e Montgom Year) 9. Birling Co 1940 Mary g. Citizen of What Co nited Stat	nery nplace (State or Foreign untry) 1 and 10d. Inside City Limits 1 □ Yes 2 ☒ No
Funeral Director 5. Social Security Number 6. Sex 1 Security Number 6. Sex 1 Security Number 7. Age (In yrs. last birthday) 1 Security Number 1 Security Nu	8. Date of Birth (Month, Day, 1) June 11,	year) 9. Birtl Co 1940 Mary g. Citizen of What Co	nplace (State or Foreign untry) 1 and 10d. Inside City Limits 1 □ Yes 2 ☒ No
Director 149–32–6963 63 Yrs.	June 11,	1940 Mary g. Citizen of What Co	1and 10d. Inside City Limits 1 □ Yes 2⊠ No
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Montgomery 10c. City, Town or Location Maryland Montgomery 10c. City, Town or Location Maryland Montgomery 10d. Zip Code 19301 Watkins Mill Road 20886 11. Marital Status 1 Dever Married 2 Married 1 Styles 2 No 1 Styles 2 No	Uı	nited Stat	1 ☐ Yes 2 No
Maryland Montgomery Montgomery Village 10e. Street end Number 10f. Zip Code 19301 Watkins Mill Road 11. Marital Status 1 Never Married 2 Married 1 Styles 2 No 1 No. Street end Number 10f. Zip Code 20886 11. Marital Status 1 Never Married 2 Married 1 Styles 2 No	Uı	nited Stat	1 ☐ Yes 2 No
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19301 Watkins Mill Road 1.1. Marital Status 1.1. Never Married 20886 1.2. Was Decedent Ever in U.S. Armed Forces? 1.3. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto R			
9	cify Yes or No- Rican, etc.)		
If Yes, Give 1 □ Yes 2 ☑ No Specify:		14. Race - Amer Black, White Specify:	
If Yes, Give Year or Dates: Korea 1 Yes 2 No Specify: 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working of work done during most of working most of working of work done during most of working most of working done work done during most of working done work done during most of working done working done work done during most of working done w	16		ite
3 Widowed 4 Divorced Pear or Dates: Korea 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 4 Bio-Chemist 17. Father's Name (First, Middle, Last) 18. Mother's Name	g	Science	naustry
17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Ma		
17. Father's Name (First, Middle, Last) Robert W. Vostreys, Sr. Robert W. Vostreys, Sr. Marie C.	Crowe		
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural	Route Number, (City or Town, State, Z	ip Code)
Marlene V. Doub (Sister) 111 Glengarry Lane, Hai		NJ 08036 0c. Location - City or 7	
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 1/		lexandria,	
21. Signature of Fyneral Service Licensee 22. Name and Address of Facility DeV	Vol Fune		VIIgIIIIa
10 East Deer Park I Gaithersburg, MD 20	Drive 0877		
Physician //Medical Examiner 23a. Part 1. Enter tyle disease for complications that cause the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Throat Cancer Due to (or as a consequence of):	respiratory erres	st,	Approximate Interval Between Onset and Death
bb.			
Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury			
Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			
d digiple of the pear of the p			
Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.	1		
es of the policy			to the ceuse of death?
be del by P P P P P P P P P P P P P P P P P P			22
The law requires that the death certain the deat	24a. Was an a performe	ad? ar	Vere autopsy findings vailable prior to ompletion of cause f death?
T Jed : Deage in the state of t	1 🗆 Yes	2 X JNo 1	☐ Yes 2☐ No
25. Was case referred to medical examiner? 1 Yes 2 No			
1 Yes 2 No No No No No No No	e 5 ∐ Residend 3d. Describe how	ce 6 □Other (Spec. rinjury occurred	ify)
1 X Natural 5 Pending (Month, Day Year) Injury Work? 1 Accident 5 Pending (Month, Day Year) Injury M 1 Ves 2 No 3 Suicide 6 Could not be determined by the d			
28a. Date of Injury 28b. Time of Specify) 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 3bb. Time of Injury 3bb	3f. Location (Stree City or Town, S	et and Number or Rui State)	ral Route Number,
25. Was case referred to medical examiner? 26. Place of Death Other: 1			
29c. License number	29d	J. Date signed (Month,	Day, Year)
D 51280	Ja	inuary 5, 2	2004
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anushiravan Dadgar, M.D. 13219 Executive PArk Terrace, (Commo + -	ATT OF) 7 <i>l</i> .
State State Altusiiiravan Dadgar, M.D. 13219 Executive PArk Terrace, (31. Date filed (Month, Day, Year) 32. Begistrar's Signature	Germanto	wи, гш 200	074

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Ite: #@cPERVFRBALG8282/21/04 Maryland / Department of Health and Mental Hygiene 2 Amended, #31&4- For State 32, TCHD, 01/08/04, sbb Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** January 2004 2005 William Webster Wright /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot Memorial Hospital Easton If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1**∑**M 2□F Director 11-22-1920 214-28-3096 Oueen Anne Co 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State **ahow** item 27 la marked other than "natural", or Items 23a or 28e-f ahov other treumatic avent, the Medical Examinas muni ke indiffied at 1 Yes 2 No Director MD. Talbot Wittman 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 4. Race - American Indian, 22581 Pot Pie Road 21676 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐Never Married 2 ☐ Married Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Saw Mill Laborer 5 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Daniel Webster Wright Mary Annie Legg

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) f Health item 27 I Isabelle Fisch (social P. O. Box 201 Wittman, Md. 21676. Worker) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Memorial 1-10-04 Easton MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Canoll R. Carroll Hurley Funeral Home, PC. Part 1. Enter the disease, or complications that caused the leath. Do not a Fertil mod Plans, 5.18 ast or reflicing 15 MD . 2166 ximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition MYOCARDIAL INFARCTION Physician resulting in death) /Medical Due to (or as a consequence of): VENTRICULAR ARRYTHMIA 2º MYUCOMENTA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 ☐ Fetel deal 2 Fetel death 3 Ectopic pregnancy Year Month Day 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2₽No ို 28a. Date of Injury (Month, Day Year) in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: **Director: After** 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide within 24 hours a To the Funerel I 29a. Certifier t 🗌 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 120059487 when trolses 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 219 S. John Botsis, Washington St. Easton, Md. 21601 MD. 82. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 0 8 2004 Registrar

			1 - For State Registrar	State of Ma	aryland / Depa	artmen rtificate			and Mo	ental Hy	gien Reg. Ne	71	04	C. Common of the common of the	673
	Dhysiai		1. Decedent's Name (First, Middle, La.	ন)					L	2. Date of De Month	eath Da	ay	Year	3. Time o	
	Physicia /Medic	_	Amy Wriston							ANUAR			2004	211	M
	Examin	er	4a. Facility Name (If not institution, give	e street and number)		100		Location o	of Death	•	40	c. County			
			Union Hospital 5. Social Security Number 6. S	7 AG	e (In yrs. last birthday)	If Under	Elkt	ON If Under:	24 Hrs.	8 Date of Ri	rth	Cec		lace (State	or Foreign
	Funeral Director			_M 2001F /	45 Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, Do Feb 13	ay, Year	2	Cour	ntry) DE	
		1	Usual Residence of Decedent			I				160 13	91/4	70			
	yland		10a. State 10b. County		10c. City, Town or Lo	ocation							1	0d. Inside C	
	e - e	ctor	MD Cecil		Elkton									1 L Yes	2. No
	or 28)ire	10e. Street and Number			10f. Zip	Code				10g. C	itizen of W	/hat Cour	itry?	
	23a	by Funeral Director	35 South Edgewo				219					USA			
	er de	nue	11. Marital Status	12. Was Decedent Armed Forces? 1 Yes 2 2	Ever in U.S. 13.	Was Deced If Yes, spec	lent of Hi offy Cuba	spanic Orig n, Mexican	gin? (Spec 1, Puerto F	cify Yes or No Rican, etc.)	0-		e - Americ k, White,	an Indian, etc.	
36	rs aft	уF	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	40	1 ☐ Yes	2 XN0	Specify:				Specify	: Wh	ite	
21215-0036	ould be tiled within 72 hours after death with the Maryland Mental Hygiene. arked other then "natural", or Items 23a or 28a-f show atto event, Ite Medical Examinat must be notified at		15. Decedent's Ed		16a. Dece	dent's Usua	al Occupa	ation			16b. l	Kind of Bu	siness/In	dustry	
215	n n	Completed	(Specify only highest gra	de completed) College (1-4or 5	lite.	kind of wor DO NOT us	rk done a se retired,	luring most)	t of workin	ng					
212	d with giene or the	ĕ	12	Gollogo (1 Horiz		estau	rant	mana	ger		6	good .	serv	ice	
2	al Hys	BeC	17. Father's Name (First, Middle, Last,					18. Mothe	r's Name	(First, Middle	, Maide	n Sumam	e)		
Ja	should bind Ment marked umatic e	2	John Wriston						am V	osburg	h				
Maryland	2 sh and is m		19a. Informant's Name/Relationship (Route Numb			State, Zip	Code)	
	1 and 3 Health tem 27 other tr		John Wriston/fax	<i>tner</i>				rive,		ark, D			Oib. as Ta	Chana	
9	Pages 1 nent of H ant: If ite ary or ot		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Removal from State	R.T. Foa Funeral	matory or o	ther place	θ)	D.	ate	20c. L	ocation -	City or 10	wn, State	
Baltimore,	permit. Pages 1 a Department of Hee Important: If item any injury or othe once.		'4 □Donation 5 □ Other (Specif	v)	Funeral	Home	P.A	e al Casille		9/2004				MD	
Bal	Deparition Department of the policy of the p		21. Signature of Juneral Service Lice	M() 1/	1	2. Name an			V.	T. Foa					
	20200		23a. Part1. Enter the disease, or com	nlications that caused				•		Newar		E 19	///	Approximat	te
	Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		OLMONAL a consequence of):	y F Wou		EIT						Interval Ber Onset and	Death
8760,	rate be executed only sician and the burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):	70900								7,00	
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o uc	ing Ph h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Inju (Month, Da	f 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No			28d. Describe how injury occurred							
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			For State		ryland / Dep		lealth and l	Mental Hygi		01674
			Registrar			7.11110410 01		2. Date of Death	J. 140.	3. Time of Death
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	Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, o	or Location of Death	n	4c. County of Death	
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	Funeral		5. Social Security Number 6. Sex		(In yrs. last birthda)) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birth	place (Stete or Foreign ntry)
	Director		214-36-5608]M 2 X F	66 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Dey, 1) October 28	,1937 Mary	yland
	and and		10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	Aary Sh	ō	Maryland Wicomic	_	Salisb	irv				1 ☐ Yes 2X No
	288-	Directo	10e. Street and Number		Darro	10f. Zip Code		100	g. Citizen of What Cou	ntn/?
	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23s or 28s-f show sumatic event, the Medical Examanar must be notified at	늅	309 Calvin Drive			2180	4		USA	
	s 23	Funeral		12. Was Decedent 8	Superior LLC 122			posity Voc or No	14. Race - Ameri	can Indian
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Baltimore,	Item oth		20a. Method of Disposition		20b. Place of Disp cemetery, cri	oosition (Name of ematory or other pla	ce)	Date 20	Oc. Location - City or To	own, State
Ë	Pages nent of I ant: If It		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	lemoval from State		1 Memory G		7/04 H	Hebron, MD	
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68	leath certificate I attending physi I for use as the b	Physician/Medi	IF FENALE.							
Вох	h cel andir use	17	1F FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome		☐Ectopic pregnanc			23d. Date of deliv	,
m	deat e attr d for	cia	in the past 12 months? 1 ☐ Yes 2 🐼 No	4 Pregnant at		Other (specify)			Month	Day Year
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	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medicai (examination and/or				ise(s) and manner as s e and place, and due t	
	within 2 To the I	Me	29b. Signature and title of certifier	2.10.11011101 310		29c. Lycen	se number	290	d. Date signed (Month,	Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Registra Amend Item / 24aper VERBALG8282/25/04 Dertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** rme OOAM 2004 /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Parole PE 115 If Under 24 Hrs. trunde 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth ___(Month, Day, Birthplace (State or Foreign **Funeral** 100M 20F Days Months Hours 212-76-3900 Usual Residence of Decedent Director with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "naturel", or Items 23a or 28a-f show treumatic event, it a Medical Examinating the notified at 1 Pes 2 □ No Director Thhupo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? tarole 2140 Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian Black, White, 1 Never Married 2 Married 1 ☐ Yes 2 If Yes, Give 2 **11** No Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) countan JONERN MAN is 1 and 2 should be filed voil Health and Mental Hygie item 27 Is marked other t 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Be alvin Serni 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nunne 40 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method Disposition Date 20c. Location - City or Town, State . Pages 1 runent of 1 1 Durial 2 Cremation 3 Removal from State ō ' 4 ☐ Donation 5 ☐ Other (Specify) injury mon 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Approximate Interval Between emopolituni 23a. Part1. Enjoy the dispersion of heart failure comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. and Deat Immediate Cayse (Final disease or condition resulting in death) Physician mmmydde /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1 ☐ Yes 2 🛣 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes ٩ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Injury at Work? 1 Natural 2 Accident 5 Pending investigation 2 No 24 hours after deal Funerel Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated within 2 To the To the 29d. Date signed (Month, Day, Year) 29b. Signature a death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) JAN 0 7 2004

30. Name and address of

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American

State of Maryland / Department of Health and Mental Hygiene State Registrar Amend Item#24aperVERBALG8282/25/04 Opertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Vear **Physician** 1330 M JANUARY 03 Gladys Davis Wieber 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner EASTUN If Under 1 Year If Under 1ALBOT HOSPITAL MEMORIAL If Under 24 Hrs. 8. Date of Birth (Month, Day, Yo 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 ☐ M 2 💢 F Hours 81 Director 496-26-0980 Alabama Usual Residence of Decedent the Maryland 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Madical Exeminer must be notified at 1 Yes 2 No Directo Caroline Maryland Goldsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 21636 or items 23a 15329 Church Ln USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify: δ 3 ♥ Widowed 4 Divorced White "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene important: If item 27 ie marked other that any injury or other traumatic event, Item 2008. 4 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Eva Mae (unknown) John Louis Davis 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Candy Cook daughter 15329 Church LN Goldsboro, MD 21636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Greensboro Cemetery 01/07/2004 Greensboro, MD 21. Signature of Funeral Service License Fleegle and Helfenbein Funeral Home PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sensis **Physician** /Medical Due to (or as a consequence of) Examiner pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physicien and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ prd Atmal, Aibrilation 1 Yes 2 No 3 Probably 4 Unknown Completed Dehydration 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 autopsy performed? certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medidal examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) d Director: After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Haiou Laura 5/04 D55484 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 219 S. Washington St Easton, Maryland <u>Haiou Laura Jin</u> 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN Registrar 6

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South Security Number Secu			_	Louise Katherine	Lerch Will	iams			January 7	2004 2004	8:40 A M	
Anne Arundel Medical Center Support Suppo			_	4a. Facility Name (If not institution, give str	reet and number)		4b. City, Town, or	Location of Death		. County of Dea	th	
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STANLE-1 NUATKINS IN 900 P1507 UATE NO ANAMULTS MO 21Y01 State 31. Date filed (Month, Day, Year) 32. P gistrar's Signature	= :	sicia cert iracti	0	examiner?	spital:	2 □ EB/Outpaties	nt 3 DOA Oth	00		6 □Other (Soe	cifu)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STANLE-1 NUATKINS IN 900 P1507 UATE NO ANAMULTS MO 21Y01 State 31. Date filed (Month, Day, Year) 32. P gistrar's Signature	5	or this eral d	-	27. Manner of Death	28a. Date of Injury	28b. Time o	f 28c. Injur	28c. Injury at 28d. Describe how injury occurred				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STANLE-1 NUATKINS IN 900 P1507 UATE NO ANAMULTS MO 21Y01 State 31. Date filed (Month, Day, Year) 32. P gistrar's Signature	ָ ס	th. : Afte	tlor		(Month, Day Yee	ir) Injury						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STANLE-1 NUATKINS IN 900 P1507 UATE NO ANAMULTS MO 21Y01 State 31. Date filed (Month, Day, Year) 32. P gistrar's Signature	ISINIC.	after dea Director	ertifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - building, etc. (Sp	At home, farm, stopecify)	reet, lactory, office				ural Route Number,	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STANLE-1 NUATKINS IN 900 P1507 UATE NO ANAMULTS MO 21Y01 State 31. Date filed (Month, Day, Year) 32. P gistrar's Signature	:	ne Hospitt 124 hours 18 Funera 18tely filler		(Check only 2 Medical Examine	er: On the basis of exar	knowledge, deat mination and/or in	h occurred at the tir evestigation, in my o	ne, date and place pinion, death occu	o, and due to the cause(s irred at the time, date an	s) and manner as od place, and due	s stated. to the cause(s)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STANLE-1 NUATKINS IN 900 P1507 UATE NO ANAMULTS MO 21Y01 State 31. Date filed (Month, Day, Year) 32. P gistrar's Signature		To th comp		29b. Signature and title of pertifier	٨		29c. Licens					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STANLE-/ NUATKINS IN 900 P1207 UATE NO ANNMULTS MO 2140/ State 31. Date filed (Month, Day, Year) 32. Positrar's Signature	ľ	_, =		Jan Marin	mvh		Do	8118	in t	rupy,	1,2007	
State 31. Date filed (Month, Day, Year) 32. Pojistrar's Signature				A 1		-	Print)	ATP Di	AM M	Jr m	2.1701	
	22	Sta	ate	31. Date filed (Month, Day, Year)	32. Pogistrar's S		0 -		10/1/01/1	0 0 000	- /	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dev Year Month **Physician** Jean Virginia Webber January 1 2004 4:35P /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🔀 F 230-20-7903 97 Director Sept.5, 1906 Washington, DC Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c. City, Town or Location rthan "natural", or itema 23a or 28a-f show the Medical Examinar must be notified at 1∏Yes 2□No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1498 Key Parkway 21702 <u>USA</u> Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 and 2 should be filled within 72 hours after. Health and Mental Hygiene. em 27 is marked other than "natural; or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced ted 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Complet Elementary/Secondary (0-12) College (1-4or 5+) Librarian US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Young Isabella Hutchinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carol Jean Webber/ 1498 Key Parkway, Frederick, MD 21702 Health Hem 27 daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of the important: If ite any injury or of once. 1 Burial 2 Cremation 3 Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Frederick Crematory 1/5/2004 Frederick, MD 22. Name and Address of FacilityStauffer Funeral Home 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, MD 21702 erses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 8 DAYS PNEUMONIA. **Physician** 4SPIRATION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 8 DAYS lueus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical the th IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼Unknown ATRIAL FIBRILLATION, PYD, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No SPINAL STENOSIS has 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ★Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t or Attanding 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗍 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD D21936 neturn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. FREDERKY Z170Z MD THOMAS LITHUSON A. DONELSON, 65-C 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Registrar

	1_ Stete	land / Department of Health a Certificate of Death		2004 01679					
	Registrar 1. Decedent's Name (First, Middle, Last)	Oertificate of Death	Reg. 2. Date of Death	3. Time of Death					
Physician	Elaine E. Warden		JAN.	Day Year 12 TM					
/Medical Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of	Death	4c. County of Death					
	St. AGNES HEALTHCAR	BALTIN Tyrs. last birthday) If Under 1 Year If Under 2		9 Birthologe /State or Foreign					
Funeral Director	5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F 7. Age (II	84 Yrs. Months Days Hours	Min. (Month, Day, Ye Nov. 19,	ar) 9. Birthplace (State or Foreign Country) Washington, DC					
P >	Usual Residence of Decedent	Oc. City, Town or Location		10d. Inside City Limits					
Maryland Its show		Catonsville		1 ☐ Yes 2 No					
with the Maryland a or 28a-f show be notified at Director	Maryland Baltimore	10f. Zip Code	10g.	Citizen of What Country?					
death with the risks 23e or 28e richard be richard be richard be richard be richard birec	719 Maiden Choice Lane, HR	21228-613	4	USA					
Steer death veriens 23steer must	11. Marital Status 12. Was Decedent Eve Armed Forces?	r in U.S. 13. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.					
1215-0036 within 72 hours atter ene. than "natural", or ite he Modical Eventine manufactural Eventine	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify: White					
21215-0036 sed within 72 hours afficient of than "natural", or or than "natural", or it has distall Exercise Completed by F	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most)	of working	. Kind of Business/Industry					
Ind 21215-00 be filed within 72 hou that Hygiene, do other than "nature event, the Medical Be Completed	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most life. DO NOT use retired)		16 7 1 1					
N Page N	17. Father's Name (First, Middle, Last)	Accountant 18. Mother	s Name (First, Middle, Maid	elf-Employed den Sumame)					
yland yland buld be fil Mental H Mental H arked ott aric even	William L. Edwards	Agne	s C. Watts						
laryland 212: 2 should be filed within and Mental Hygiene. 8 marked other than aumatic event, the M To Be Comp	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number		ty or Town, State, Zip Code)					
, Ma and 2 salth s	Elisabeth Cupples/ Sister	7425 Democracy Blv							
Baltimore, Maryland Semil. Pages 1 and 2 should be file Department of Health and Mental Hy mportant: If item 27 is marked oth any injury of other traumatic event and in the contract of the	20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill J.	anuary 10	. Location - City or Town, State					
timen rant:	* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Cemetery	2004 Su	itland, Maryland					
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury of other traumatic events.	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Francis J. Coll 500 University	ins Funeral H Blvd. W., Sil	lome Inc. ver Spring, MD 2090					
	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.			Approximate Interval Between					
Physician	Immediate Cause (Final disease or condition	eumple		Onset and Death					
/Medical Examiner	resulting in death) Due to (or as a c	onsequence of):	landa 5	2 mel					
e le le le le le le le le le le le le le	Sequentially list conditions, if any, leading to immediate b. Supply (or as a consequence of): Supply Sup								
executed in and in-transit	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
O, 00, 100, 100, 100, 100, 100, 100, 100	resulting in death) Last Due to (or as a c	onsequence of):							
68760, ificate be executed g physician and as the burial-transit edical Examin	d								
Box 6 Box 7 Box 7	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of			23d. Date of delivery					
E E WARE Records, P.O. Box 6 The law requires that the death certif the has been signed by the attending sage 2 should be detached for use a completed by Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown			Month Day Year					
P.O at the at the stacker	9 Unknown	Ministration and the second in Double	22a Did tahan	co use contribute to the cause of death?					
dS, ires th signed d be d	Part II. Other significant conditions contributing to death but if	uste himdring 30 years	1 ☐ Yes	200 No 3 Probably 4 □Unknown					
II Record The law require page 2 should Completed	a har with subselect	I laws extranter	24a. Was an	24b. Were autopsy findings available					
Relay age 2	and all the second	a equito (xaa e viii eq	autopsy performed						
/ Nital	25. Was case referred to medical 26. Place of Death (Check only one)								
A NE NITAL FOR VITAL FUND SCHOOL PARTIES CONTINUED AND AUTHORITY PARTIES OF TO BE CONTINUED TO BE CONTINUED AND AUTHORITY PARTIES OF TO BE CONTINUED AND AUTHORITY PARTIES OF TO BE CONTINUED AUTHOR	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
On O	27. Manner of Death 1 ☑ Natural 2 ☐ Accident investigation 2 ☐ Accident	ear) 28b. Time of 28c. Injury at Work? M 1 Yes 2 N	28d. Describe how i	njury occurred					
Division of Vital Records or Attending Physicien: The law requires after death. Director: After this certificate has been sign in by the funeral director, page 2 should be ertification; To Be Completed by	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury	- At home, farm, street, factory, office	28f. Location (Stree	t and Number or Rural Route Number,					
Division of Division of State death. By the funeration of the funeration;	4 Homicide determined building, etc. (Specify)	City or Town, S	(are)					
NAME ELAINE Division of Vital Recomplete Hospitel or Attending Physicien: The law within 24 Hours after death. To the Funerel Director: After this centificate has completely filled in by the funeral director, page 2	(Check only 2 Medical Exeminer: On the basis of en	ny knowledge, death occurred at the time, date and camination and/or investigation, in my opinion, deat							
NAN the Hospi thin 24 hou or the Funer mpletely fill	one) and manner state 29b. Signature and title of certifier .	d. 29c. License number	29d.	Date signed (Month, Day, Year)					
	Dama & Biribas	D2211	4 /1	6/04					
10	30. Name and address of person who completed cause of dea	th (Item 23a) (Type Print) ORMDAN &	E RECOHE	is no					
	5411 OLD FREDERETE ROUP,	SUDTER, BALTEMOR	E MARYCA	and diddi					
State Registrar	JAN 0 9 2004 32. Registrar's	SUDTE 18, BALTEMON							

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** \mathbf{P}^{M} JANUARY 2004 WIESENFELD 7.00 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 01/03/1909 09?-09-9085 NEW YORK Director 94 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow Examiner must be notified at 1 Yes 2 No Directo MARYLAND MONTGOMERY POTOMAC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Items 23a Funeral 1727 SUNRISE DRIVE 20854 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after MYes 2 □ No 1 Yes, Give Year or Dates: WWII 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: WHITE þ 3 Widowed 4 □ Divorced "natural", the Medical Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. CLAIMS EXAMINER WORKMAN'S COMPENSATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Health and Mental le marked 2 WIESENFELD BT.UMA LEFKOWITZ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages.
Department of Health a...
Important: If item 27 ler
eny injury or other tra 1727 SUNRISE DRIVE, POTOMAC, MD 20854 PAUL R. WIESENFELD/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 01/05/2004 4 □ Donation 5 □ Other (Specify) NATIONAL CREMATORY FALLS CHURCH, VERGINIA 21. Signature of Funeral Service 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DURECTION,
1091 ROCKVILLE PIKE, ROCKVILLE, Donald. 23a. Part1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line. h. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** O Cavala /Medical Due to (or as **Examiner** Sacuentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): burial-Box 68760 Physiclan/Medical the IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy õ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No director Be 25. Was case referred to medical 26. Place of Death Check on one examiner' Other: 4 Jursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 P 1 🗌 Yes 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury thin 24 hours after death, the Funeral Director: A mpletely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) no completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 6/21 Montrose Kd Rockville GOR. 31. Date filed (Month, Day, Year) State 32. Registrar's Signature IAN 0 7 2004 Registrar

			1- For AMFID#10e, fiper IN Registrar AMFID#11per MD1	State of Maryland / [Department of H Certificate of L	ealth and Mo	ental Hygier	re ne no. 2004	01681
R	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last Alice Wilson Alice Wilson As Eacility Name (If not institution, give	Merce non			2. Date of Death Month January 0	Day Year 04, 2004	3. Time of Death 5:45 P M
		ier	Carriage Hill Nur: 5. Social Security Number 6. S	sing Home	Bethe	sda		Montgom	ery
	Funeral Director			TH OFFE OO	Yrs. Months Days	Hours Min.	B. Date of Birth (Month, Day, Yea Oct. 18,	1915 Tex	nplace (State or Foreign untry) .as
	e Marylan la-f show	ctor	Maryland Montgon		Bethesda				10d. Inside City Limits 1 ☐ Yes 2 No
	th with th	ai Directo	10e. Street and Number 5225 Pooks Hill Ro	1310 oad, Apt. 130- Sout	10f. Zip Code 20814			Citizen of What Cou	untry?
036	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show allost Examinar mark be notified at	Completed by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🎇 No		ify Yes or No- ican, etc.)	14. Race - Amer Black, White Specify: Wh	
Maryland 21215-0036	within one. than	ompleted	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	College (1-40(5+)	Decedent's Usual Occupa (Give kind of work done d life. DO NOT use retired) Homemaker	ation <i>furing</i> most of working)		Kind of Business/li	ndustry
yland 2	should be filed and Montal Hygie marked other imatic event, It	To Be C	17. Father's Name (First, Middle, Last) Arthur McFa	rland			illiamson		
	s 1 and 2 sh f Health and Item 27 is rr other traurr		19a. Informant's Name/Relationship (1) Margo London / 2 20a. Method of Disposition	Daughter 5	Mailing Address (Street a 112 Nahant S Disposition (Name of y, crematory or other place	t., Bethe	sda, MD	or Town, State, Zi 20816 Location - City or T	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic events.		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	Mt. Co	mfort Cremat 22. Name and Address	ory Jan. 7	ph Gawler	's Sons,	Inc.
	Physician /Medical		23a. Part1. Enter the disease, or companies shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	- 1600	adder Cancer	, such as cardiac or		hington,	Approximate Interval Between Onset and Death 3 Months
1760,	Examine executed mysicien and he burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of Due to (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a)	of):				
.O. Box 687	that the death certificate ed by the attending phys detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♥ No 9 □ Unknown	d	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deliv Month	ery Day Year
<u>α</u>	The law requires that to the law requires that to the has been signed by the lage 2 should be detailed.	þ	Part II. Other significant conditions co	ontributing to death but not resulting in	the underlying cause give	n in Part I.		_	he cause of death?
al Records,		Completed					24a. Was an autopsy performed? 1 Yes 2X N	prior to co death?	opsy findings available impletion of cause of
of Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	04	26. Place of Death (Check only one) 5 Residence	6 ☐Other (Specif	(y)
Division o	Hing After fune	Certification:	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		jury Work?	at 28	d. Describe how inju		
Divi	i gife		4 Homicide determined	building, etc. (Specify)		ī	f. Location (Street a City or Town, Stat	te)	
	the Hospital thin 24 hours a the Funeral I mpletely filled	edicai	29a. Certifier 1 \(\sum \) Certifying Phyone (Check only one)	/sician: To the best of my knowledge, iner: On the basis of examination and and manner stated.	death occurred at the time Vor investigation, in my opi	e, date and place, an nion, death occurred	d due to the cause(s at the time, date an	s) and manner as s nd place, and due to	tated. the cause(s)
	To the within to the complex c	Σ	29b. Signature and title of certifier	(latter)	29c. License D00119			ate signed (Month, uary 6, 2	
			Dr. John Galotto 5			Bethesda	MD 20814		
***	Sta Registr	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	4 Sports				

			1 - For State Registrar	State of Mary	rland / Depa		Health and	Mental Hygie	ne 2001	4 01682
	Physici /Medic		1. Decedent's Name (First, Middle, Kenneth J. Wolf	e, Jr.				January		12:20₽
jk.	Examir Funeral Director	er	4a. Facility Name (If not institution, Washington Adve 5. Social Security Number 213–38–2039	entist Hospita	yrs. last birthday)	Tako	or Location of Dea ma Park If Under 24 Hr Hours Mir	s. 8. Date of Birth		
	the Maryland 28a-f ehow	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince 10e. Street and Number		c. City, Town or Lo	ocation			Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2 🛣 No
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Examer must be motified at once.	by Funerai Dir	9118 Riggs Rd 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 12 Yes 2 No If Yes, Give Year or Dates:	1957_	20783		Specify Yes or No- rto Rican, etc.)	USA 14. Race - Am Black, Whi	erican Indian,
21215-0036	l within 72 hor ione. r than "natura the Medical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	during most of w	orking 16t	Kind of Business	s/Industry
Maryland 2	hould be filed d Mental Hyg marked other matic event,	To Be C	17. Father's Name (First, Middle, La Kenneth J. Wolf 19a. Informant's Name/Relationship	e, Sr.			Dorot	me (First, Middle, Maid hy Hoopes Jural Route Number, Ci	den Sumame)	
Baltimore, Ma	Pages 1 and 2 s ment of Health an ant: If them 27 is ury or other trau		Frances R. Wolf 20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3 1 □ Donation 5 □ Other (Spe	e/Wife	9118 Ob. Place of Dispo cemetery, crer Loudon F	Riys R esition (Name of natory or other pla Park Crem	d, Adelr	hi, MD 2078 Date 2000	83 .Location - City or Baltimo	r Town, Stete
Balt	permit. Departi Import. any nj		21. Signature of Funeral Service Li	Daniel	11	800 New	Hampshir			Home ng, MD 20904 Approximate
68760,	Coate be executed Medical Physician and Street and and and and and and and and and and	dicai Examiner	23a. Part1. Enter the disease or conditions shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	insequence of:	Liver				interval Between Onset and Death Server March
.O. Box (The law requires that the death certifica tie has been signed by the attending ph bage 2 should be delached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown]Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	olivery Day Year
Records, P.	w requires that been signed by should be deta		Part II. Other significant condition	s contributing to death but no	ot resulting in the u	nderlying cause gi	en in Part I.	23e. Did tobacc		o the cause of death? robably 4 □Unknown
_		Be Completed	25. Was case referred to medical				26. Place of De	24a. Was an autopsy performed 1 Yes 2 at (Check only one)	? prior to death?	utopsy findings available completion of cause of
Division of V	ding Phy J. After this funeral c	ဥ	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga		2 ER/Outpatien 28b. Time of Injury	28c. Inju	ner: 4 ☐ Nursing	Home 5 Residence		acify)
Divis	i te	ai Certification:	3 Suicide 6 Could no determin		pecify)		me, date and place	28f. Location (Street City or Town, St	ate)	,
)		Medical	(Check only 2 Medical Exone) 29b. Signature and title of certifier	caminer: On the basis of exa	mination and/or inv	29c. Licens		29d.	Date signed (Mont	
	Sta Registi		30. Name and address of person with MOBACH LA LANGE (Month, Day, Year) JAN 08	21M, 7610 32. Apgistrar's	CARROLL	Print)	UE, THY	OMAT PARK	· ; MD	20912

		-	For State Registrar	State of M	laryland		artmen rtificate					giene Reg. No. 2	004	01	683
	Physicia		Decedent's Name (First, Middle,								2. Date of Dea Month	Day	Year	3. Time o	of Death
	/Medic	al	John Joseph Yo		-)		4h City	Toum or	Location of	of Death	Jan.	4,	2004 nty of Death	7:30	рм
120	Examin	er	4a. Facility Name (If not institution, 9 654 Bay Green		,		4b. City,	Arn		or Coult			nne Ar	undel	
	Funeral Director		5. Social Security Number 366–16–7456	.Sex 7.A	ge (In yrs. la 84		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day Aug. 22	y. Year) 2, 1919	9. Birth Cou	place (State ntry) MI	or Foreign
	and w	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	ocation							10d. Inside (City Limits
	Maryl -f aho	tor	MD Anne	Arundel			Ar	nold						1 🗌 Yes	2 ₹ No
	death with the Maryland ma 23a or 28a-f ahow	Funeral Director	10e. Street and Number 654 Bay Green D	rive			10f. Zip		21012	2		10g. Citizen	of What Cou		
21215-0036	be filed within 72 hours after death with the Marylan Hygione. d other than "natural," or frama 23a or 28a-f show event, the Wedical Exam as must be notified at	ρ	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Typy 2 □ If Yes, Give Year or Dates:	.?]No WW.	II	Was Deced If Yes, spec				ecify Yes or No- Rican, etc.)	E	Race - Amer Black, White cify:		
2-0	72 ho	eted	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece	dent's Usua kind of wor DO NOT us	rk done d	uring mos	t of work	ing	16b. Kind o	f Business/Ir	ndustry	
2	within iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5 +	5+)		S Nav	,	,			Ņ	Milita	ry	
20	e filed other vent,	BeC	17. Father's Name (First, Middle, La	rst)					18. Mothe	er's Name	e (First, Middle,	Maiden Sun	iame)		
ylar		To	Frank Joseph Yo								lna Myer				
Maryland	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationshi Madeline R. You								al Route Numbe arnold,		wn, State, Zi 1012	p Code)	
	s 1 an of Heal item 2 other		20a. Method of Disposition		CA	ace of Dispo	sition (Nar	ne of			Date	20c. Locatio		own, State	
altimore,	Pages nent of ant: If it ary or o		1 XBurial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe		9	ingto				Jan.	21,	Arlir	igton,	VA	
Balt	permit. Pages Department of Important: If i any injury or 20028.		21. Signature of Fyneral Service L	censes			arran 95 Go	d Addres CO & V. R	s of Facility Sons	b, P.	A. Seve	erna Pa erna Pa	ırk Fu ırk, M	neral D 211	Home 46
Ш			23a. Part . Enter the disease, or c shock, or heart failure. List of	omplications that cause nly one cause on each	ed the death. line.					1 -				Approxima Interval Be Onset and	etween.
H	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or a	ronla	0b	SMY	de	-01	ilmo	my o	21180	18		
Ę	Examiner			Supplied to (of a	CL CC	SICK	SIS		_ `)				
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	s a conseque	ence of):									
	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	s a conseque	ence of):							-		
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89	ntificate ng phy as the		IF FEMALE.	123101											
.O. Box	that the death certificate be executed ted by the attending physician and detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1□Live birth 4□Pregnant 9□ Unknown	2 Fetal	death 3	□Ectopic pi □ Other (sp				- Para - marriago de la colonia de la coloni		Date of delive Month	rery Day	Year
s, P.	The law requires that the ste has been signed by th page 2 should be detache	by Ph	Part II. Other significant condition	s contributing to death	but not resul	lting in the u	underlying o	ause give	en in Part I	Ι.	23e. Did to	obacco use c	ontribute to	the cause of	death?
space	w require been sig should be	ed b	- Noningulinac	pendeto	llaha	5					101	res 2□No	3 Pro	bably 4	Unknown
Vital Record	e law re has be je 2 sho	Completed	- Selec GER	0/01	rs						24a. Was autop		b. Were aut prior to co death?	opsy findings ompletion of	s available cause of
al H			-Sue odeo	parais:	2010	/an	pen	15K	101	9	1 ☐ Yes	2000 .	1 Yes	2 No	
	Physician: The this certificate har al director, page	To Be	25. Was case referred to medical examiner? 1 \sum Yes 2 \sum \text{6}	Hospital:	tient 2 E	R/Outpatie	J	Othe	ar	e of Deat ursing Ho	me 5 Resid		Other (Spec	ify)	
ر ا	ng Phy ter thii neral o		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of In		28b. Time o		28c. Injury Work			28d. Describe I	now injury oc	curred		
Division	r Attending er death. rector: After by the fune	Certification:	2 Accident investigation inves	ot be 28e. Place of li	njury - At hor	me, farm, st	M reet, factor		Yes 2 🗆	INo	28f. Location (: City or Tox		ımber or Ru.	al Route Nu	mber,
۵	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical Cer	(Check only 2 Medical E	Physician: To the bes	st of my know	vledge, dea									(s)
	To the h within 24 To the f complete	Med	one) 29b. Signature and title of certifler	and manner :	Stated.		29	c. License	number			29d. Date siç	ned (Month	, Day, Year)	
)	⊢ ≯ ⊢ ŏ		1 (ahaoo Ti	re Hanlo	um	MO		ni	1078	21		1/0	110	4	
			30. Name and address of person v	no completed cause of	Ldeath (Item	23a) (Type	Print)		-	Na	val A	cade	my	Clin	
	- 04	ato	31. Date filed (Month, Day, Year)	32. Red 3	ane strar's Signati	ure	401	IN	1	Hn	napol	15 M	-01	2140	1
	Pogist	ate	0.74.4.4	2 2004		he	Ann A	2 .							

			For State Registrar	State of M	aryland / [irtment of H <i>tificate of L</i>				eneZ (g. No.	104	0 684
			1. Decedent's Name (First, Middle,	Last)					2	. Date of Death Month	Day	Year	3. Time of Death
	Physici /Medio		Evelyn	Link	An	dra	9		J	January		004	2:00 p M
	Examin		4a. Facility Name (If not institution,			,	4b. City, Town, or					y of Death	
87			Bon Secours Hos	-			Baltimor				N/.		
24	Funeral Director		217-34-6095	- CT CT	je (In yrs. last bir 95	rthday) Yrs.	If Under 1 Year Months Days	Hours	Min.	Date of Birth (Month, Day, Lug. 5,	1908	9. Birthp Cour Mar	lace (State or Foreign try) yland
	land w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or Lo	cation					1	0d. Inside City Limits
	Mary I sho	tor	Maryland Howard		Baltim	ore							1 ☐ Yes 2 🖺 No
	r 288	Director	10e. Street and Number		1		10f. Zip Code			10	g. Citizen of	What Cour	itry?
	h with		5930 Setter Dr	ive			21075	j			USA		
215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Exerting transit by muffled at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? d 1 ☐ Yes 21€ If Yes, Give Year or Dates:	,		Vas Decedent of Hi Yes, specify Cuba	ispanic O in, Mexica Specify		fy Yes or No- can, etc.)	Bla	ce - Americ ick, White, fy: Whi	etc.
2	72 hc	etec	15. Decedent's (Specify only highest	Education grade completed)	16a.	Deced	ent's Usual Occupa	ation	st of working	1	6b. Kind of E	Business/Inc	dustry
2	Mithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work done d NOT use retired emaker)			0	II	
2	filed with Hygien Sther the	ပိ	12 17. Father's Name (First, Middle, La	est)		пош	emaker	18 Moth	ner's Name //	First, Middle, M	Own		
an	m = 0 5	To Be			irae			Ida		F.	Apple		
Maryland 21	should be and Mental smarked o umatic eve	F	19a. Informant's Name/Relationshi	o (Type, Print)	19b	. Mailin	g Address (Street a	and Numi	per or Rural F	Route Number,	City or Town	, State, Zip	Code)
	alth a alth a 27 is		Charles W. Andr	ae Jr. (Son	1) 5	930	Setter D	r.,	Baltin	nore, MI	2107	5	
ore,	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		20b. Place of	f Dispos	sition (Name of Packy or other place Cremator		Dat	e 2	0c. Location		wn, State
Ĕ	Pages ment of ant: If It ury or o		'4 □Donation 5 □Other (Spe		Loudo	n P	ark	1	1/24/0)4 Ba	altimo	re, M	aryland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny injury or other traumatic evonce.		21. Signature of Funeral Service Li	cens t		22	Name and Addres	s of Faci	lity Loud	lon Park	Fune	ral H	ome
_	ā0		23a. Part1. Enter the disease, or c				620 Wilke					2122	9 Approximate
*	Physician /Medical Examiner	Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. As position of the contract	a consequence		neu m	mi	3				Interval Between Onset and Death
68760,	eath certificate be executed attending physician and for use as the burial-transit		resulting in death) Last	Due to (or as	a consequence	of):							
_		ledical		U									
.O. Box	The law requires that the death certified has been signed by the attending tage 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal death		Ectopic pregnancy Other (specify)					ate of delive onth	ry Day Year
٠. ح	s that	by Pr	Part II. Other significant condition	s contributing to death b	out not resulting in	n the un	derlying cause give	en in Part	l.	23e. Did toba	cco use con	tribute to th	e cause of death?
200	w requires that been signed to should be deta	q pa	Malmita	in: Car	liences					1 ☐ Yes	2 🗆 No	3 Prob	ably 4 Wunknown
Division of Vital Records,		Completed	Renol (ailure						24a. Was an autopsy performe	ed?/	Were autoprior to condeath?	osy findings available inpletion of cause of 2 No
Vite	icien. Sertifik ector,	Be	25. Was case referred to medical examiner?	Hospital:			0#			Check only one			
0	Physical direction	٠ <u>.</u>	1 ☐ Yes 2 12 No 27. Manney of Death	1 Inpatie		tpatient		4 🗆 N		5 Residen)
U _O	ding P h. After t funera	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Da	y Year)	njury	28c. Injury Work	rai (? Yes 2.[d. Describe how	injury occur	ilea	
VISI	or Attendated death Director:	Certification:	3 Suicide 6 Could no	t be 28e. Place of In	ury - At home, fa	ırm, stre	et, factory, office		28f			ber or Rura	Route Number,
	tel or rs afte el Dir ed in	Cert	4 Normolde	Building, et	c. (Specify)				Į.	City or Town,	State)		
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best caminer: On the basis of and manner st	f examination an	e, death id/or inv	occurred at the tim estigation, in my op	e, date a pinion, de	nd place, and ath occurred	d due to the cau at the time, dat	ise(s) and m e and place,	anner as st and due to	ated. the cause(s)
)	Tot withi To I	Σ	29b. Signature and title of certifier	esty.	,		29c. License	17	537		,	19-	04
	h	1	30 Name and address of person w DARSHIP S 31. Date filed (Month, Day, Year)	SALUAM	death (Item 23a)	(Type, I	MOUNT!	Rojet	Ave,	B. U	2	12-1	7
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	A	parket						
DH	Registr		WAN 2 3 2004	Jan Phil	/-	1	VII.	ing dalam dalam dalam da					

			For State Registrar	State of Maryla	and / Depa <i>Cei</i>	artment of rtificate of	Health and Death		jien 👂 🕦 🗓	01685
	Physici /Medic		1. Decedent's Name (First, Middle, Last)		130	RNS		2. Date of Dear	th Day Yea ARY 20, 20	
	Examir		4a. Facility Name (If not institution, give s	1-1200 POCH		BALTIM		th	4c. County of De	ore city
	Funeral Director		5. Social Security Number 6. Sex 216-03-2837	M 2□F 7. Age (In y	rs. last birthday) 90 Yrs.	If Under 1 Yea Months Days			Year) (irthplace (State or Foreign Country) ryland
	death with the Maryland ms 23a or 28a-f show thiust be notified at	ctor	10a. State 10b. County MD Baltimore		City, Town or Lo					10d. Inside City Limits 1 □ Yes 2 ☑ No
	23a or 28	al Director	10e. Street and Number 3117 Dubois Avenue	1		10f. Zip Code 21234			Og. Citizen of What (
	nours after deat tural, or itams 2 al Example (1911)	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 ☑ No		Specify Yes or No- rto Rican, etc.)		nerican Indian, nite, etc.
Maryland 21215-0036	within 72 iene. 'than "nat the Medic	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occu kind of work don DO NOT use retir	during most of we	orking	16b. Kind of Busines Bakery	
yland 2	be tile ital Hyg id othe evant.	To Be C	17. Father's Name (First, Middle, Last) Thomas E. Burns				Catheri	me <i>(First, Middl</i> e, M ne Fritz		
Baltimore, Mar	permit. Fages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic ODE.		19a. Informant's Name/Relationship (Type Ms. Margaret Sue B 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Re 1 □ Donation 5 □ Other (Specify)	urns/Daughte	er 3117 b. Place of Dispo cemetery, crem	Dubois P sition (Name of natory or other pl	venue, P	arkville, Date : Jan 22	20c. Location - City o	or Town, State
Baltir	permit. P Departme Importan any injur		21. Signature of Funeral Service License		986 22	ke Crema Name and Addi Cremation 3717 Gree	ess of Facility n and Fun	eral Alte	Beltsville ernatives Baltimor	
60,	Medical be executed by sician and provided and the prijal-transit the build-transit	dical Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of):	Lyocke	siñ i	NFARCT	0~	Approximate Interval Between Onset and Death
Box 6	e attending i	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	Ectopic pregnand Other (specify)	>y		23d. Date of do	l Blivery Day Year
	sign d be	ed by PI	Part II. Other significant conditions conf	ributing to death but not i	resulting in the ur	nderlying cause g	ven in Part I.			to the cause of death? Probably 4 Hunknown
I Rec	ate has b	Complet						24a. Was ar autopsy perform 1 Yes 2	y prior to ned? death?	utopsy findings available completion of cause of s 2 No
Division of Vital	i je i	To Be	27. Manner of Death	ospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year,	28b. Time of Injury	28c. Inju	her: 4 \sum Nursing I	ath (Check only one Home 5 Reside 28d. Describe ho	nce 6 Other (Sp	ecify)
Divis	s after de al Diracto	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe	t home, farm, streecify)	et, factory, office		28f. Location (Str. City or Town,	eet and Number or F , State)	lural Route Number,
	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical ((Check only 2 Medical Examin	cian: To the best of my ker: On the basis of exam and manner stated.	nowledge, death ination and/or inv	restigation, in my	opinion, death occ	urred at the time, da	ite and place, and du	e to the cause(s)
)	with	₩	29b. Signature and title of certifier	tel	ns	D :	se number		Date signed (Mon	20,2004
	(npleted cause of death (em 23a) Type	WINS CENT	HOSPING 20th	- 5601 L	nore Ma	BULLVALD EYLAND 21239
	Sta Registr		31. Date filed (Month, Day, Year)	82. Registrar's Sig	natura	parkel				•

4-0472	For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of rtificate of	Health and M f <i>Death</i>	lental Hy	giene ()	04	01686
Dhysisian	Decedent's Name (First, M.	iddle, Last)				2. Date of De	eath Day	Year	3. Time of Death
Physician /Medical	Mattie	Bell	Dav	is	Booker		RY 17,		0949 A M
Examiner	4a. Facility Name (If not institute 700 W. LEXING)		or Location of Death ORE CITY		4c. Count	ty of Death	
Funeral Director	5. Social Security Number 249-76-2892	1□M ¾Ω Æ	ge (In yrs. last birthday) 58 Yrs.	Months Days		8. Date of Bi (Month, Di 04 0	ay, Year)	9. Birthpla Countr	
and w	Usual Residence of Decedent 10a. State 10b. Cou		10c. City, Town or Lo	ocation				100	d. Inside City Limits
Aarylis F eho		,						100	1 ☑ Yes 2 ☐ No
with the Ma or 28a-1 or percutties	MD NA 10e. Street and Number		Baltimo	10f. Zip Code			10g. Citizen of	What Countr	~?
3 or	5016 Carmin	o Drivo			21207		U.S		,,
6 after death ver thans 23 circumstant	11. Marital Status	12. Was Decedent	Ever in U.S. 13.		Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No	o- 14. Ra	ce - America	
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 77 te marked other than "natural; or Itams 23e or 28e-1 show other traumatic event, the Medical Examinat must be notified at To Be Completed by Funeral Director	1 Never Married 2 Never Marri	If Yes Give	No	II Yes, specify Cul		Rican, etc.)	Speci	ack, While, et fy: B1	.ack
Baltimore, Maryland 21215-0036 sernit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mental Hygiene. Importent: If item 27 le marked other than "natural", or my njury or other traumatic event, the Medical Examinate. To Be Completed by F	15. Dece (Specify only high	dent's Education phest grade completed) 2) College (1-4or	(Give	dent's Usual Occu kind of work done DO NOT use retin	e during most of work	ing	16b. Kind of E	Business/Indu	ustry
d with	10th grade	na na		se Keep	per		Hos	pital	_
be filed that Hygin dother event, Be Cc	17. Father's Name (First, Midd	dle, Last)			18. Mother's Name	e (First, Middle	, Maiden Suma	me)	
Vlan Ments Ments Arked Arked To E	Nathaniel D	avis			Karen Ev	vans			
2 sho and 1	19a. Informant's Name/Relati	onship (Type, Print) Daug	hter 19b. Maili	ng Address (Stree	et and Number or Run	al Route Numb	er, City or Town	, State, Zip C	Code)
re, Mass 1 and 2 if Health a tiem 27 le other trau	Annette Dav	is-Jackson´	1110		ester Dr:	ive, N	ew Mar	ket,	Md 2177
of He	20a. Method of Disposition	on 3 Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	lace)	Date	20c. Location	- City or Tow	m, State
Pag Pag ment ent: J	`4 Donation 5 Dothe	r (Specify)		n Cemet	tery 1/24	4/04	Balti	more	Co, Md
Baltimorr permit. Pages Department of the Important: If ite any injury or of pages.	21. Signature of Funeral Serv	rice Licensee	M	2. Name and Addr larch F		Dal+	imoro	ма э	1215
	23a. Part1. Enter the disease shock, or heart failure.	, or complications that cause	d the death. Do not en	ter the mode of dy	ring, such as cardiac	or respiratory a	rrest,		Approximate nterval Between
Physician	Immediate Cause (Final								Onsel and Death
/Medical	disease or condition resulting in death)	a. Lue to (or as	s a consequence of):	HEN IVV / 10	3496				
Examiner		Hypom	VACVANIAL (s a consequence of): -VITUE CAVA	ligyastila	- nicesso				
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icate be executed physician and sthe burial-transit cdical Examiner	that initiated events	1 c							
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8760, cate be exphysician at the burial dical Ex		d							
riffica	IF FEMALE:		- 4						
Records, P.O. Box 68 The law requires that the death certific ste has been signed by the attending p page 2 should be detached for use as completed by Physiclan/Mec	23b. Was decedent pregnant in the past 12 months?	23c. Il yes, outcome 1 ☐ Live birth		Ectopic pregnanc	cy			ate of delivery	
O. E e dea	1 Yes 2 No	4☐ Pregnant a 9☐ Unknown	at time of death 5	Other (specify)			M	onth D	ay Year
P.O	Pod il Other significant con	ditions contributing to double	but not condition in the .		and a Double	an- Did			
IS, Fres that signed be del by P	Part II. Other significant con-	ultions contributing to death t	out not resulting in the t	inderlying cause g	pven in Part I.				cause of death?
w requir						1 🗆	Yes 2 No	3 Probat	oly 4 Unknown
Division of Vital Records, to Attending Physicien: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by			·			24a. Was	psy	prior to come	sy findings available pletion of cause of
						1 Yes	ormed? 2 ☐ No	death? 1 Yes 2	□No
/ita	25. Was case referred to med examiner?			1.2	26. Place of Deatl	(Check only	one)		
of Vita Physicien: this certificated director,	1 XYes 2 No		ienI 2 ER/Outpatie	III 3 DOA	ther: 4 🗆 Nursing Ho	me 5□Resi	dence 6 XIOti	her (Specify)	AT SCENE
Division c Division c stal or Attending P is after death. al Director: After I ed in by the funera Certification:	27. Manner of Death	28a. Date of Inj (Month, Da	ay Year) 28b. Time o	We		28d. Describe	how injury occur	rred	
Vision Attending r death. ector: After by the fune	E C Prisona of it	estigation uld not be			☐Yes 2☐No				
Division of the safer death of the birector: I in by the ertifical		ermined 286. Place of In	iju ry - At home, larm, st tc. <i>(Specify)</i>	reet, lactory, office	9	28f. Location (City or To	Street and Num. wn, State)	ber or Rumal I	Route Number,
oital ours all or all of illed i	Ly								
Division of Vita Division of Vita To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be (29a. Certifier 1 ☐ Certi (Check only 2 ☐ Medi one)	fying Physician: To the best cal Examiner: On the basis of	of examination and/or in	h occurred at the to evestigation, in my	time, date and place, opinion, death occurr	and due to the ed at the time,	cause(s) and m date and place.	anner as stat and due to the	led. he cause(s)
thin 2 the imple	29b. Signature and title of cer	and manner s	Tated.	29c Licen	ase number		29d. Date signe	nd (Month, Di	av Voge)
2 × 1 8	b olgitalist and initial	and the		230. 2100.1	OCME	,	JANUARY		
.1	7	1011.							_
n	30. Name and address of pers	son who completed cause of			pot Polt	more :	Maran - 1 '	2120	
State	31. Date liled (Month, Day, Yo	ear) + 30 Reniel	rar's Signature	rem SM	eet, Balti	nore, I	латАтаро	1 2120	T
State Registrar	1	N 9 2 200 s		1	Life Control				
DHMH 17 Rev 1/2001	J!	111 60 6004	Walnut S	Cook	0				
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State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day,

Wyman

Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004

Park

32. Register's Signature

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760.

DRIVE

29c. License number

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29d. Date signed (Month, Day, Year)

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RJ			·			em4bState of 23a,pt.II,27	,28a-f p	er me	itificat	5/8 1	Death			Z U U 4	01000
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4		Examin	er	4a. Facility Name (If not institution	n, give street and num	ber)		4b. City,	Town, o	r Location of Deat	h	4	c. County of Dea	th
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7		Funeral		5. Social Security N		6. Sex 7	7. Age (In yrs 41	iast birthday Yrs.	Months	Days	Hours Min.	8. Date of B (Month, L 8/6/1	Day, Yea Q 6 1	r) 9. Bir	thplece (State or Foreign ountry) RYLAND
04		Director		212-78-2 Usual Residence o		1111						0/0/1	901	PIA	XILAND
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		death with the Maryland ms 23s or 28s-f show r must be notified at	Funeral	11. Marital Status		12. Was Dece	dent Ever in U	.S. 13.	. Was Dece	dent of H	lispanic Origin? (S	pecify Yes or N	10-	14. Race - Am	
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	7	led w lygier her ti	S	12	(Circh Middle	(ant)		EL	ECTRI	ULAN	18. Mother's Na	me (First Midd	lo Maide	ELECTI	KICAL
	ī	be fi	Be	17. Father's Name BRUCE B	•	Last/		-				RA SUML		an comame,	
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	<u>Ja</u>	12 st h and 7 is n		19a. Informant's N			-11 17				ROAD, E				
		1 and Health		BONNIE 20a, Method of Dis		NA	20b. F	Place of Disp			KOAD, L	Date	_	Location - City or	
	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any nighty or other traumatic event, the Medical Examinal must be notified at once.		1XXBurial 2	Cremation	XXRemoval from S	State	JOSE	ematory or o	ther pla		5/2004			TOWNSHIP, NJ
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		To the Hospital or within 24 hours after To the Funeral Director completely filled in the Funeral C	edical	(Check only one)	2/ZMedica	Examiner: On the ba	asis of examina	ation and/or	investigation	n, in my o	opinion, death occ	urred at the tim	e, date a	ind place, and du	e to the cause(s)
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () () For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** BLACK 5:49AM OREE JANUARY 21 2004 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hospital Secous MOV-E 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** 1 □ M 2 💢 F Months Days Hours Min. 213-30-5111 September 3, 1932 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County "netural", or Items 23a or 28e-f show the Medical Examination must be notified at 1 Dores 2 □ No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21216 Lou 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married **≋**Ĝ No Baltimore, Maryland 21215-0036 1 Tes Specify: þ 3 Widowed 4 □ Divorced Black Be Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "ne any injury or other traumatic event, the Media. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coltege (1-4or 5+) LOUNdr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Moses ဂ Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Street Ballimore, MD aven D. Blac Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State tovest let Jumy 27, 2004 Ow Mgs Mills, MD Garrison 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 638 N. Gilnor Street 231. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. 21217 Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and ned for use as the burial-transit The law requires that the death certificate be executed Due to (or as a conseq of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached? 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☒ No 24a. Was an autopsy performe certificate 1□ Yes 2⊅No or Attending Physician: completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Nonpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation Injury 1 Alatural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PHYSILIAN 57597 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLVD BALTIMORE MO 21230 SANDHU 700 , WAJHINGTON 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 🤈 🗎 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1751 **Physician** Beirnette 2004 Martha January 16 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner BA HTWE CITY OF THE STREET OF NA The Johns Hopkins 6. Sex HUSDITAI 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1□M 2💢 F 214 30 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Show r items 23a or 28a-f show ther must be notified at 1√ZYes 2 No **Funeral Director** M 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. Street 21205 1400 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 Yes 2 ₹NO Specify: the Medical Exar ģ BIACK 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. 101585 7 is marked other traumatic svent, I 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be HAISEN ပ 19a. Informant's Name/Relation ip (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) i: If itsm 27 is r or other train Gen BURDIE 20b. Place of Disposition (Name of permetery, crematory or other place) MD BELL taulcer Date 20c. Location - City or Town, Stete 20a. Method of Disposition ŧ 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Department of Important: If any injury or once. 23 103 PARK tellmore MD permit. 22. Name and Address of Facility Bells 21. Signature of Funeral Service Licensee CARGLINE alucia 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myocardial **Physician** in farction day /Medical Due to (or as a consequence of): **Examiner** day Respirating failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed heart disease Coronary burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician 5 years Obstructive Lung disease Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Dav Year for 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 XYes 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2♥ No 24a. Was an autopsy 1 ☐ Yes 2 🗷 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 🕱 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat. To the Funeral Director. 6 Could not be 3 🗍 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier, RES-500 Annay 19, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthe De Ruiter The Johns Hipkins Huspital, 600 N. Wolfe Street Baltinere, Mayland 21283 31. Date filed (Month, Day, Year)

JAN 2 3 2004 732. Registrar's Signature State ment. Registrar

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** January 17, 2004 11:05 AM Marie Henrietta Bruner /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Montgomery Wilson Health Care Center Gaithersburg 8. Date of Birth (Month, Dey, Dec 15, If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 102 Yrs. 1901 Maryland Director 705-05-2867 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 28a-f show r than "naturel", or items 23a or 28a-f shov the Medical Examiner must bu catified at MD Montgomery Gaithersburg 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 407 Russell Avenue 20877 USA Funeral 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) secretary B&O railroad othar t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Peges 1 and 2 should be f Department of Health and Mental I Important: If Item 27 Is marked or Simon Assen Bruner Frances Henrietta Berghammer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Helen Turowski/cousin 2419 Cider Mill Road Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State * 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signature of Euneral Service Licensee any ir irector 23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) month Physician oveamoni /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or in jury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospitel or Attanding Physician: The law requires that the death certificate be executed nding physician and use as the burial transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has Cevelw vaicular 1 Tes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Yes 2 No □ Surring Home 5 Residence 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred the funeral 27. Manner of Death 28b. Time of After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director; A 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier January 17, 2004 pleted cause of death (Item 23a) (Type, Print) Gaitherbuy, Md. 20179 Russell 911 The 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 23 Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Month Year **Physician** 21, 2004 **JANUARY** 11:25am AGNES LEE BROWN /Medical 4a Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner BALTIMORE N/A FUTURE CARE SANDTOWN If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Months Min. 1 ☐ M 2 其F Director 12-23-1913 MARYLAND 066-16-0213 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, Stete 10b. County Hygiene. other than "naturel", or items 23s or 28s-f show rent, the Madical Examiner must be notified at 1 ☐ Yes 2 ☐ No BALTIMORE N/A Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21215 USA Funeral 3709 DORCHESTER RD. within 72 hours efter death 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes ≥ 2 ☐ No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK Š 3 ₩ Widowed 4 Divorced Completed Decedent's Usual Occupetion
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY GOVERNMENT 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be f and Mentel h permit. Pages 1 and 2 should I Department of Health and Ment Important: If Itam 27 is marked JOSEPH LEE AGNES PENNINGTON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DELORES BISHOP(NIECE) 3228 DORITHAN RD. BALTIMORE. MARYLAND 21215 other 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 6 injury 4 ☐ Donation / 5 ☐ Other (Specify) ARBUTUS MEMORIAL PARK 1-28-2004 BALTIMORE, MARYLAND HIBNER Name and Address of Fecility PHILLIPS FUNERAL HOME, P.A. 21. Signature of herel Service Licensee JONATHAN D. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Atheroschotte Cosdiv Vasulas Disease Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of) Examiner physicien ends s the burial-transit m the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of): 8 attending p USB signed by the at Id be deteched fo 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? After this certificate has been situated the funeral director, page 2 should Completed 21/No 1 TYUS 1 ☐ Yes 2 ☐ No ours after deeth.

eral Director: After this certification by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Viving Home 5 Residence 6 Other (Specify) Hospital: 2 No Medical Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury et Work? 28d. Describe how injury occurred 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide or A To the Hospital e within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner es steted. 2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 37 75 1- 22-04 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DARSHAN S. SALUA 1600 W. Mo U 1600 W. MOUNT Roy & Are 32. Registrer's Signeture 31. Dete filed (Month, Day, Year)

Registrar DHMH 16 Rev 6/95

State

2 3 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Jan 20 2004 7:200 **Physician** Norman F. Connelly /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Gilchrest Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State of Country)
Nov. 25 1935 Maryland Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Months Days 1**X**]M 2□ F 68 216-30-7250 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County rthen "natural", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 No Essex Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21221 USA 5 Brett Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Security Security Guard es 1 and 2 should be filed wi of Health and Mental Hygien filem 27 is marked other th 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maryland Be Catherine E. Higgs William J. Connelly Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14 E. Starwood Court Baltimore MD Patricia Bruchey/daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of It Important: If ite any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State DulaneyValley 1/24/04 Baltimore MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee 300 Mace Ave. Baltimore MD 21221 onne 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Aspiration preumonia weeks recurrent Physician /Medical Due to (or as a consequence of) ysphagia, due To debility and Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last remote History of prior neck surgery Examine physician and s the burial-transit Due to (or as a consequence of): P.O. Box 68760, death certificate be Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy certificate ha 2 No 1 ☐ Yes Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 (Specify) HOSpice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Menner of Death 28a. Date of Injury (Month, Day Year) ical Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 4 - Homicide hours after within 24 hours at To the Funeral D completely filled in Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Ped I 29d. Date signed (Month, Dey, Year) 29b. Signature and title of JAnuary 21, 2004 1)25205 no h who completed cause of Genth (Item 23a) (Type, Print)

GAMC 6701 N. Charles St. Balts. and 21204 6701 G R.mc 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Maryla	and / Dep <i>Ce</i>	artment of F	lealth and N Death		ene2 0 0	+ 01694
П	Physici	an	1. Decedent's Name (First, Middle, La					2. Date of Death Month	Day Yea	3. Time of Death
	/Media	al	Eugene Denard			4h Cihi Taum a	al continue of Dooth	1 1		9 M
	Examir	er	4a. Facility Name (If not institution, given 171 Chapeltowne (, and the second	r Location of Death		4c. County of De Baltim	
	Funeral		5. Sociel Security Number 6. S	Sex 7. Age (In y	rs. last birthday,	ff Under 1 Year	ry Hall If Under 24 Hrs.	8. Date of Birth		irthplace (State or Foreign Country)
	Director		218-36-9948	XX ^{M 2□ F} 63	Yrs.	Months Days	Hours Min.	July 31,	1940 Ma	aryland
	pur *		Usuaf Residence of Decedent 10a, State 10b, County	100	City, Town or L	neation		-		10d. Inside City Limits
	Maryli f sho	ō	Maryland Baltimo	1	-	y Hall				1 ☐ Yes 2 No
	the r	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What	Country?
	h with	al D	171 Chapeltowne (Circle		21236	·)		USA	
	ems ems	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi	nerican Indian,
36	s afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1			Specify:	,		White
Ö	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-f show ta Meulcal Examinar naral be notified at	ed b	15. Decedent's E		16a Dece	dent's Usual Occup	ation	16	b. Kind of Busines	e/Industry
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Maryland 21215-0036	nd 2 sh lith and 27 is n r treun		19a. Informant's Name/Relationship (Eugene Callaway,	•	19b. Maili			al Route Number, C		
ē,	Heal Heal tem 2	3	20a. Method of Disposition			sition (Name of			Ltimore. c. Location - City of	MD 21211 or Town, State
OE	Pages nent of int: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special		altimor	matory or other place e-Washing	rton'	4/2004 L	aurel. Ma	nwland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other treumatic svent, If a Medical Examination and be notified at ance.		21. Signature of uneral Service Lice		Grem	atory 2. Name and Addres		Funeral H		
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de one cause on each line.	eath. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arrest	,	Approximate Interval Between
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oʻ	an an		resulting in death) Last	Due to (or as a cons	equence of):					
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Вох	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pred 1 Live birth 2 Fe 4 Pregnant at time o	etal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of d Month	elivery Day Year
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<u>a</u>	res that igned b be deta	by Pi	Part II. Other significant conditions of	contributing to death but not r	esulting in the u	nderlying cause give	en in Part I.	23e. Did tobac	co use contribute	to the cause of death?
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<u>=</u>	The cate h	Соп						performe		-
Vita	ilcian: The lav certificate has rector, page 2	Be	25. Was case referred to medical examiner?	Hospital:		Oth		Check only one		Daugh Teris
of Vital Records,	Physician: r this certifica ral director, I	<u>1</u>	1 Yes 2 No 27. Manner of Death	1 Inpatient 2 28a. Date of Injury	ER/Outpatier		4 Nursing Ho	me 5 Residence 28d. Describe how		ecity) Residence
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ō	ital or A	Cer		Summing one. (Spe						
/	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only 2 Medical Exar	sysician: To the best of my k niner: On the basis of exami	nowledge, deat	h occurred at the tim	ne, date and place, pinion, death occurr	and due to the caus	e(s) and manner a and place, and du	is stated. e to the cause(s)
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)	Z Z Z S		1/achin10	101			3076		1/19/07	,,,
	n		30. Name and address of person who	completed cause of death (II	em 23a) (Tvpa					
	7		16 dwel	i Diam.	nol	3730	5 Falls	Re	Balt n	el 21211
	Sta	te	31. Date filed (Month, Day, Year)	9 3 Registrar Sig	nature	book	,			

			For State Registrar	State of Marylar		artment of H			giene () () ()	01695
	Physicia	an	1. Decedent's Name (First, Middle, Las	Doris F.	Cook			2. Date of Dea Month	Day +h Yea	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Death	bhuar	4c. County of De	0 1.33
	Funeral Director		210-20-1450	Hospital Ce ex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March2	Year	nore firthplace (State or Foreign Country) aryland
	yland		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation			,	10d. Inside City Limits
	sa-f st	ctor		ltimore			Baltimore			1 ☐ Yes 2 📉 No
	with th	Dir	10e. Street and Number 404 Scarsdale	Road		10f. Zip Code 2122	4		USA	Country?
36	permit. Pagas 1 and 2 should be filad within 72 hours after daath with the Maryland Department of Health and Mental Hyglena. Department of Health and Mental Hyglena. Important: If item 27 is marked other than "neturel", or Items 23a or 28a-f show any injury or other treumatic evant, the Nedical Franker must be rollified at 900ce.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give			ispanic Origin? (Spe in, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)		•
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d 21	filad w Hygler ther th		9th 17. Father's Name (First, Middle, Last)		W &	itress	18. Mother's Name	(First, Middle,	Reste	raunt
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Maryland	12 sho h and l 7 Is ma treuma		19a. Informant's Name/Relationship (1	-	and Number or Rura d Road B		r, City or Town, State	
	t Healt f Healt item 2		20a. Method of Disposition	l ,	Place of Dispo	sition (Name of natory or other place	D	ate	20c. Location - City	
Baltimore,	Pagar ment o ant: If ury or		1 ☐ Burial 2 🛣 Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify)	Hemovai from State Ra	yview	Cremato	$\operatorname{ory} = 1/2$	2/04	Baltimor	re MD
Balt	permit. Departi Import any inj		21. Signature of Funeral Service Licer	Connelles			MAce Ave	. Balt	imore MI	IomeofEssex 21221
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	Physician /Medical		disease or condition resulting in death)	a. Gastro II	nte5:	tinal	Bleed			2-3 hours
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/	Hospital	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death ation and/or in	n occurred at the tim vestigation, in my op	ne, date and place, a pinion, death occurre	and due to the cared at the time, d	ause(s) and manner ate and place, and di	as stated. ue to the cause(s)
	To the Hospital within 24 hours a To the Funeral completely filled	Me	29b. Signature and the of certifier			29c. License	number	2	9d. Date signed (Mo.	nth, Day, Year)
	. (1/ State	time on			1668		1/19/04	
	9		30. Name and address of person who				min Par	Himm	e MD a	1237
	Sta Registr		31. Date filed (Month, Day, Year) AN 2 3 201	32 Registrar's Signa	ature	age of		ال		

DHMH 17 Rev 1/2001

Cook, Doris

		T = State Registrar	State of Maryland	Cer	rtificate of L	Death		Reg. No.		
	3	Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death
hysicia		Anthony	Kingsle	V	Ce	asar	Januar	v 21	O4	7:15a.
/Medic Examin		4a. Fecility Name (If not institution, give s			4b. City, Town, or	Location of Death			ty of Death	
		4 Mill Point Co	urt		Owings	Mills		Balt	timo	re
ineral		5. Social Security Number 6. Sex	3	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	th V Yearl	9. Birth	place (State or Forei
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i al	cto	MD Baltimo	re Owin	gs M	Mills					1 □ Yes 2√□X
s 23a or 28a-f shov wat be notified at	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	intry?
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	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. V	Was Decedent of His If Yes, specify Cubar	spanic Origin? (S n, Mexican, Puert	pecify Yes or No Rican, etc.)	- 14. Ra	ace - Amen ack, White	
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ant		'4 Denation 5 □ Other (Specify)		g_Me	morial H	Park 1/	26/04	Randa	llst	own, Md
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	10		30. Name and address of person what TIMOTHY IOW						11 1/2 /22	.1 -	V50571 75	117	1 .00,000		
	Sta Registr		31. Date filed (Month, Day, Year)		trace Signature		Ann.		JWSOr 	M. IV	IARYLAI	VD. 21	1.204		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** January Cedar Dolores 16. 2004 12:04 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Georges Southern Maryland Hospital Clinton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2X F Yrs June 28,1930 Washington. Director 577-42-9864 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 TYes 2 No Directo Maryland | Prince Georges Forest Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5806 Blackhawk Drive 20745 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 🔀 Married Specify: White 1 ☐ Yes 2 CKNo Specify: ρ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fife Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 9008. 17. Father's Name (First, Middle, Last) O'Connor Maurice Margaret Cecil 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Herbert E. Cedar / Husband 5806 Blackhawk Dr., Forest Heights, MD 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation

5 ☐ Other (Specify) 1/20/2004 Suitland, MD Washington National 22 Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 meral Service Licens 21. Signature Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Samentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last m Due to (or as consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 2 No 1 🗆 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28c. Injury at Work? 28a. Dat of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending DIVISIO
To the Hospital or Attendi
within 24 hours after death.
To the Funeral Director: A investigation 6 Could not be determined 3 C Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier (Check only one)

> SALMANINO - 5801 ALLENTIUN 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1) 35-65-6

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar			State o	of Mary	/land / D	epar C <i>erti</i>	tment	of H	ealth a	and M	lental H	Hygier Reg. I	1.4046	004	0	599
	_	Decedent's Name	(First, Middle	, Last)									2. Date of Month		Day	Year	3. Time	of Death
Physicia: /Medica		Doro	othy		Louis	se	Cook	ζ					Janu			2004	1:45	A M
Examine		4a. Facility Name (II	f not institution	give str	eet and nu	mber)			4b. City, 1	Town, or	Location	of Death			4c. Cou	nty of Deatl	1	
		St. Agn	es Hosp	oital	L						nore					N/A		
Funeral Director		5. Social Security No. 327-05-78		6. Sex 1 ☐ N	4 2⊠F	7. Age (lr 95	n yrs. last birth Y		If Under Months		If Under Hours	Min.	8. Date of (Month,	, Day, Ye	ar) 190	9. Birtt Co.	untry)	e or Foreign
D .		Usual Residence of 10a. State	Decedent 10b. County			10	Dc. City, Town	or Loca	tion								10d. Inside	City Limits
aryla shor	5																	es 2⊠ No
the N	Director	Maryland 10e. Street and Nun		more			Cator	1SV1	10f. Zip	Code				10a.	Citizen	of What Co	untry?	
with with		715 Mai		oico	Lane					1228						SA	,	
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fter d	Funeral	1 Never Marri	ied 2□ Marri	ed	Armed Fo	2 No							Rican, etc.)		Black, White		
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72 ho	Completed	(Snec	15. Decedent				16a. (Deceder	nt's Usua	Occupa	ation during mos	t of worki	ina .	16b	. Kind of	f Business/l	ndustry	
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be fill tall H od oth	Be	17. Father's Name	(First, Middle, i	Last)		0							(First, Mic	_			مد د اد د	
d Mer narke	္	Philip 19a. Informant's Na	Detekteret	in Cons	O-i-4)	Cart		t de ilie e	Address	(Ctro at a		Haze]		Iren		wn, State, Z	yder	
12 st h and 7 is n traun		Mary K.				er)		_								, D.C.)3
Heatt		20a. Method of Disp					20h Place of	Disposit	tion (Nam	e of			Date			on - City or		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ⊠Burial 2 (Cremation		noval from	State	Dulaney					1/23/	' 04	- D11	ılanı	ey Val	llev.	MD
nit. F artme ortan injur e.		21. Signature of Fu					- Memor	1a1	Car Name and	dens Addres	s of Facili	ty Lo	oudon	Park	Fu	neral	Home	
Depa Impo any i			2													D 2122		
CHOSEN	- 11	23a. Part1. Ent	disease, or rt failure. List	complica	tions that	caused the	e deeth. Do no	ot enter	the mode	of dyin	g, such as	cardiac o	r respirato	ry arrest,			Approxin	nate Between
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/Medical		resulting in death)	1	a.	-11		onsequence o											
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s that	by Pl	Part II. Other signif	ficant condition	ns contr	ibuting to d	death but n	not resulting in	the und	derlying ca	ause give	n in Part	1.	23e. D	Oid tobacc	co use c	ontribute to	the cause	of death?
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The law requires that the death certifica are has been signed by the attending phoage 2 should be detached for use cst	Completed													Vas an	24		topsy findin	gs available
The lav ate has page 2	HO												, p	erformed es 2 🗆		death?	2 No	. 02300 01
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tendi leath. tor: A the fu	catl	2 Accident 3 Suicide	investig 6 □ Could i	- 1			AA h		M	7.	Yes 2		206 Lanatic	on (Ciron	e and Mi	ımber or Ru	m / Pouto N	umber
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Certification;	4 Homicide	determ	ined	build	ding, etc. (- At home, far Specify)	m, stree	et, factory	, office				Town, St		ander or no	iai riobio i	Biribor,
spita nours neral		29a. Certifier	1 Certifyin	g Physic	cian: To th	e best of n	ny knowledge,	death (occurred a	at the tin	ne, date ar	nd place,	and due to	the cause	e(s) and	manner as	stated.	
n 24 h	Medical	(Check only one)	2 Medical	Exemine	er: On the l	basis of ex nner stated	amination and	Vor inve	stigation,	in my o	oinion, dea	ath occuri	ed at the ti	me, date	and plac	ce, and due	to the caus	θ(s)
To the Tro the comp	Ž	29b. Signature and							29c		number	m				ned (Monti	-)
7		P h	i hi	· m	0					0.	C.M.	C •		Jar	ıudr	y 20,	2004	
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Registra	ar	JAN 2	3 2004		All mit		P	RP	alla									

		State of Marylan	Certificate o	Health and Mental I f Death	Reg. No.	4 0 700
	1. Decedent's Name (First, Middle, Last)		2. Dete o		3. Time of Death
Physician /Medical Examiner	CURTIS IVANHOE CAN			JANUX 4b. City, Town, or Locetion of D	1ky 20 20	ear 204 1320 Death
Examiner	MERCY MEDICAL CENT			 BALTIMORE	N/A	
Funeral	5. Social Security Number 6. Se	x 7. Age (In yrs.	lest birthday) If Under 1 Yes Months Dey			. Birthplace (State or Foreign Country)
Director	216-24-2127	XM 2□ F	72 Yrs. Months Dey			IRGINIA
pu *	Usual Residence of Decedent 10a. Stete 10b. County	10c Cih	/, Town or Location			10d. Inside City Limits
Manyla f sho						XX Yes 2 □ No
permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Instrumet or them 21s a restrict other than 'natural', or them 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	MARYLAND N/A 10e. Street end Number	BAL	TIMORE 10f. Zip Code	3	10g. Citizen of Who	et Country?
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r Items 234 Inner must Funeral	11. Marital Status	12. Was Decedent Ever in U,	S. 13. Was Decedent of	f Hispanic Origin? (Specify Yes outland, Mexicen, Puerto Rican, etc.	No- 14. Race -	American Indian,
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d by	3 ☐ Widowed 4XXDivorced	If Yes, Give Year or Dates: 196	0			LACK
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that die	Elementary/Secondary (0-12)	College (1-4or 5+)	LONG SHOREM		SHIPPI	VC.
T O	17. Father's Neme (First, Middle, Last)		LONG SHOKER	18. Mother's Name (First, Mid		NO
To Be	ROSERVELT CAVANAU	טי		REBECCA RANDO	три	
umat T	19a. Informant's Name/Relationship (T)		19b. Mailing Address (Stre	et and Number or Rurel Route Nu		ate, Zip Code)
er tra	HATTIE L. JOHNSON	(SISTER)	4010 WEST FRA	NKLIN STREET; I	BALTIMORE,	MARYLAND 21229
tto .	20a. Method of Disposition		lace of Disposition (Name of emetery, crematory or other p	Date	20c. Location - Cit	y or Town, State
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page 2 should				24a. V	Vas an autopsy 2 erformed?	4b. Were autopsy findings available prior to completion of cause of death?
rector, page 2 Be Comp					LI Yes 212/No	1 ☐ Yes 2 ☐ No
Be C	25. Was case referred to medical			26. Place of Death (Check or		1 162 2 100
- O	evaminer?	lospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient 3□ DOA	other: 4 Nursing Home 5 R		Specify) Hospice
in: T	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury 28c. In		be how injury occurred	opening [105pice
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pletely fille edicai C	29a. Certifier (Check only one) 1 ☐ CertifyIng Phys	ner: On the basis of exeminati	viedge, death occurred et the on and/or investigation, in my	time, date end place, and due to a point on the control of the con	the cause(s) and manne ne, date end place, and	er es steted. due to the cause(s)
To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1	29b. Signature end title of certifier	and manner stated.	29c. Lice	nse number	29d. Pate signed (A	fonth, Day, Year)
8	DAT !		7/1	NSSU	1 20/20	
\ X`	30. Name end address of person who co	mpleted cause of death (free	23a) (Type Print)	0007	20(3	• • •
10	David, Rise			PL. Baltim	ore 213	903
	31. Date filed (Month, Day, Year)	32. Registrer's Signat				

Registrar DHMH 16 Rev 6/95

JAN 2 3 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O. O. I.

			for State Registrar	State of Ma	*	partment of F ertificate of			ene 2 0 0 1	+ 01701
			Decedent's Name (First, Middle, Las	it)				2. Date of Death	n Day Year	3. Time of Death
-	Physicia /Medic	_	THELMA TYN	IES CA	REY			Jan	20 200	Y. C. / V/M
	Examin		4a. Fecility Neme (If not institution, give	street and number)		4b. City, Town, o	r Location of Death	V	4c. County of De	
			LEVINDALE GERIA	TIC HOSP	ITAL	BALTIM			N/A	
	Funeral Director		5. Social Security Number 6. Sr 213-34-8180 1	ex 7.Age □M 2.2XF	(In yrs. last birthdo	Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug. 12	, 1935 9. B	rthplece (State or Foreign syntry)
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or					10d. fnside City Limits
	B Ma	cto	M.D. N/	A	Balti	more				1X Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	Og. Citizen of What C	Country?
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9036	ours after death with the Maryland ral', or items 23a or 28a-f ehow Exacities must be coulled at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 🏝 Divorced	12. Was Decedent E Armed Forces? 1 Yes 22 No If Yes, Give Year or Dates:	ver in U.S. 1	3. Was Decedent of H ff Yes, specify Cuba 1 ☐ Yes 2 □XNo		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: B1	ite, etc.
	ours "natural"	etec	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. De (G	cedent's Usual Occup ive kind of work done a. DO NOT use retired	ation during most of work	ing 1	16b. Kind of Busines Departme	
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2	itied with Hygiene. other then		10th		100	ch super	18. Mother's Name			Delvices
Maryland 21	d ta D	To Be	17. Father's Name (First, Middle, Last) Augustus Hamil		ms		Nellie			
	ind 2 should alth and Men 27 is marke		19a. Informant's Name/Relationship (Malcolm Tynes -			ailing Address (Street 8 Fairfa:				
Baltimore,	Pages 1 an nent of Heal int: If item 2 iry or other		20a. Method of Disposition ↑★ Burial 2 ☐ Cremation 3 ☐ ↑ 4 ☐ Donation 5 ☐ Other (Specify		cemetery, o	sposition (Name of crematory or other place wn Cemeto	ce)		Balto., M	
Balti	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Lices	L. Nut	tei	22. Name and Addre 2501 Gwy:	nnsfalls	Pkwy l	Balto.,M	me Inc. .D. 21216
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused	the death. Do not	enter the mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate interval Between
	ysician		Immediate Cause (Final disease or condition	multi	- Enfa	act Os	mentia			Onset and Death
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	± 00 m		IF FEMALE:							
P.O. Box	that the death certifined by the attending detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at the 19 Unknown	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _	у		23d. Date of d Month	elivery Day Year
٥	that ned b e deta	by Pł	Part II. Other significant conditions of	ontributing to death bu	t not resulting in th	e underlying cause giv	ven in Part I.	23e. Did tob	acco use contribute	to the cause of death?
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ita		Be	25. Was case referred to medicaf examiner?				26. Place of Deat	h (Check only one	9)	
<u>Ş</u>	> 0 0	To	1 ☐ Yes 2 No		nt 2 ER/Outpa		4 Nursing no		nce 6 Other (Sp	ecify)
	Jing After fune	stion;	27. Manner of Death 1 ★Naturaf 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injun (Month, Day	Ye <i>ar)</i> 28b. Tim fnju	y Wo	ry at rk? Yes 2 □No	28d. Describe ho	w injury occurred	
Division	i i i i e	Certification:	3 Suicide 6 Could not be determined		ry - At home, farm, . (Specify)	street, factory, office		28f. Location (Str City or Town	reet and Number or I , State)	Rural Route Number,
H	the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical C		nysician: To the best on the basis of and manner state	examination and/o					
	within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed (Mor	
			1			056	508		Jan 21	, 2004-
	X		30. Name and address of person who	completed cause of de	eath (Item 23a) (Ty	0:0 5-63-61	VGRONG	SHAO	<i>y</i>	
	1		2434 W Belvest	ere live	Bol	limore,	m			
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	timore, 1				
	Registi	ar	JAN 2 3 2004	July 1	1 17					

			1 - State Registrar	of Maryland / Dep Ce	ertificate of		Reg.	_4004	01702
ı	Physici	an	1. Decedent's Name (First, Middle, Last)	Chestnut				Day Year	4 3 3 014
	/Medic Examir		William 4a. Facility Name (If not institution, give street and n		·, · · · · · · · · · · · · · · · · · ·	r Location of Death	January	18 200 4c. County of Dea	
	LAdillii	iei	Union Mem. hospital			timore		NA	
3	Funeral Director		5. Social Security Number 6. Sex 1√2 M 2 □ F	7. Age (In yrs. last birthday 72 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 2-10-31	ear) 9. Bi	nthplace (State or Foreign ountry) . C .
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
	Mary	tor	Md NA	Baltir	nore				1 X Yes 2 ☐ No
	or 28	Oirec	10e. Street and Number		10f. Zip Code	_	10g.	Citizen of What C	ountry?
	s 23a	ral	1911 29th Street		2121			USA	
36	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "natural", or Itams 23e or 28e-1 show marked other than "natural", or Itams 25e or 28e-1 show marked other than "natural burnallised at the marked of the Maryland Examinar than burnallised at the marylan	by Funeral Director	Armed I	cedent Ever in U.S. 13. Forces? 13. 25. No Sive X Dates:	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
Š	72 ho	ted	15. Decedent's Education (Specify only highest grade completed	16a Dece	edent's Usual Occup	ation	16b	. Kind of Business	/Industry
7	Athin ne.	Completed		(1-40(3+)	b kind of work done of DO NOT use retired	()		D Winner	I mD
5	filed within Hygiene. ther than out, the Mark		9th grade 17. Father's Name (First, Middle, Last)	Chai	uffer	18 Mother's Name	e (First, Middle, Maid	P Winner	LID
Maryland 21215-0036	Mental Mental arked o	To Be	Willie	Chestnut	-	Carrie	o (1 mor, micoro, marc	Best	
ary	s 1 and 2 should f Health and Men itam 27 Is marke other traumatic	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street a	and Number or Run	al Route Number, Cit	y or Town, State,	Zip Code)
	1 and 2 Health and 27 I						Baltimore,		218
more,	m O		20a. Method of Disposition 1√□ Burial 2 □ Cremation 3 □ Removal from	20b. Place of Disp cemetery, cre	osition (Name of matory or other plac	(e)	Date 20c	Location - City or	Town, State
=	permit. Page Department Importent: If any injury or once.		t ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur: Funeral Service Licensee	ALDULUS	Mem. Pk.		4-04 <i>P</i>	rbutus,M	id.
Ba	permi Depa Impo any i		21. Signatura de l'uneral Service Licensee		2. Name and Addres			nore, Md.	
	1		23a. Part1. Enter the disease, or complications that	caused the death. Do not en	March F.H. ter the mode of dying		or respiratory arrest,	North A	Approximate
	Physician		(shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition	yocaka	100	inla	Retre	7	Interval Between Onset and Death
É	/Medical Examiner		resulting in death) Due to	(was a consequence of):	,, ,	f			a minute
	LXammer	-	Sequentially list conditions, b	o (or as a consequence of):					
	uted I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	(or as a consequence or).					
ó	exection and and rial-tra		that initiated events c	(or as a consequence of):					
8760	sate be executed physicien and the burial-transit	cal	d			 	^		
9	certificate be executed iding physicien and ise as the burial-transit	73	IF FEMALE:						
.O. Box	death e atter	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	nant at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
ري م	s that ined b	by Pi	Part II. Other significant conditions contributing to	death but not resulting in the t	inderlying cause give	en in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ğ	law requires that the as been signed by th 2 should be detache		Sepsis				1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Dinknown
Il Records,	The ate h page	Completed	Acyte Reno	al fai	lur	<u>e</u>	24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of
Vital	Attending Physician: Thr death. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner? 1 \(\text{Ves} \) 2 \(\text{T.M5} \) Hospital:		Othe	26. Place of Death			
ō	Phys	. To	1 163 2 (1	Impatient 2 ER/Outpatien of Injury 28b. Time of Injury Injury	nt 3 DOA	at □ Nursing Hor	me 5 Residence 28d. Describe how in		cify)
<u>0</u>	nding lath. Ith. It After e funer	atlon:	1 ☑Natural 5 ☐ Pending (Mo 2 ☐ Accident investigation	nth, Day Year) Injury	f 28c. Injury Work M 1 🗀	? (es 2 □ No		,4.7 00041.04	
Division	r Attendi er death. rector: A by the fu	ertificat	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plac built	e of Injury · At home, farm, st	reet, factory, office		28f. Location (Street City or Town, St		ural Route Number,
5	ital or urs afte rel Dir	OI							
/	To the Hospital or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one) 2 Medical Examiner: On the	e best of my knowledge, deat basis of examination and/or in nner stated.	h occurred at the tim vestigation, in my op	e, date and place, a inion, death occurre	and due to the cause ed at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	othe outhin omple	Mec	29b. Signature and title of certifier	mer stated.	29c. License	number	29d. [Pate signed (Monti	h, Day, Year)
	./		Verenies	Emter	A	T243	8946 So	in 12	2004
	1/		30. Name and address of person who completed cau	se ath (Item 23a) (Type, M.D.	Print)		3) 16		, 2007
			Veronica Epstein	VM.D. O	nion Me	morial t	tospital	Balti	nare, mp
100	A 1 1 1 1 1 1 1	300	21 Date filed (Ments Dec Vers)						
利、	Sta Registra	100	31. Date filed (Month, Day, Year) 32.	R sistrar's Signature	de!				

		_	1 - For State Registrar	S	State of	Maryla		artment of F rtificate of		d Mental Hy	ygien Reg. Ne	C. UU	+ 01703
	Physici /Medio		1. Decedent's Name (First, Midd	le, Last)	C	Coc-105	5			2. Date of D Month	eath Da	y Year	3. Time of Death
	Examin		4e. Facility Name (If not institution			ber)	e.he-	4b. City, Town, o	Location of C	Dealh	7 3	County of Deal	el Cital
	Funeral Director		5. Social Security Number	6. Sex 1 □ M	20 F	7. Age (<i>In yr</i> s 93	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of 8 (Month, D	irth ay, Ye <i>ar</i> 10	9. Bin	thplace (Stete or Foreign ountry) 5 . C .
	aryland show	_	Usual Residence of Decedent 10a. State 10b. Count Md . NA			10c. C	ity, Town or Lo Baltim						10d. Inside City Limits 1 ☑ Yes 2 ☑ No
	with the Mi a or 28a-f	Director	10e. Street and Number 4016 Southern				Darcin	10f. Zip Code	.206		10g. C	itizen of What Co USA	
36	d within 72 hours after death with the Maryland Jene. r than "natural", or Itams 23a or 28a-1 ehow the Medical Epartmer must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	12.	Was Dece Armed For 1 _ Yes If Yes, Giv Year or Da	2 No			ispanic Origin	? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Ame Black, Whit	
21215-0036	within ane. then	Completed	15. Decede (Specify only high) Elementary/Secondary (0-12)			-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of d)	f working		Kind of Business	
Maryland 2	filed Hyg othe	To Be Co	6th grade 17. Father's Name (First, Middle James	Last)		Carlo		tory Work		Name (First, Middle)			arlos
Mary	d 2 should be th and Menta! 7 is marked traumatic ev		19a. Informant's Name/Relation Saretha Rawl:			ghter				or Rural Route Number Baltimor			
Baltimore,	Pages 1 and 3 nent of Health ant: If Item 27 ary or other tra		20a. Method of Disposition 1 Burial 2 Cremation 2 Other (3 □Rem		20b. State	Place of Dispo	osition (Name of matory or other place	(8)	Date 24-04	20c. L	ocation - City or insdowne	Town, State
Balti	permit. Pages Department of Important: If I any injury or once.		2 Signature of Funeral Service		bette	ru In	2:	2. Name and Addre March F.H			imor . No	re, Md. orth Ave	21202
	Physician /Medical Examiner	_	23a. Parth. Enter the disease, of chock, or heart failure. Lis immediate Cause (final disease or condition resulting in death) Sequentially list conditions,	a b	Due to (aused the dea	quence of):	ter the mode of dyin		rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c d	,	or as a conse		-					
.O. Box 6	the death certifi y the attending iched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c.	1 Live bi	come of pregr rth 2 Fel ant at time of wn	al death 3	Ectopic pregnancy Other (specify)		YM Y		23d. Date of del Month	ivery Day Year
rds, P	uires tha signed d be de	by	Part II. Other significant condit	ions contrib			-	inderlying cause giv				\/	the cause of death?
Il Records,		Completed	Diatetes	ico						24a. Wa auto perl 1 🗆 Yes	s an opsy ormed? 2.2 No	prior to death?	atopsy findings available completion of cause of
n of Vital	Physic r this ce ral dire	on: To Be	25. Was case referred to medic examiner? 1 Yes 2 No 27. Manner Death 1 atural 5 Pend	Hos	1 ∐ lf 28a. Dale d		ER/Outpatier 28b. Time o Injury		er: 4 Nursir	Death (Check only ng Home 5 \sum Res 28d. Describe	idence		cify)
Division	I or Attending after death. Director: Afte I in by the fune	Certification:	2 Accident invest 3 Suicide 6 Could	igation not be	28e. Place buildir	of Injury - At l ng, etc. <i>(Spec</i>	home, farm, strify)	M 1 □	Yes 2 □ No	28f. Location City or To			ıral Route Number,
9	Hospita 4 hours Funeral ely filled	edical C	29a. Certifier 1 Cartify (Check only one) 2 Madica	ng Physici I Exeminar	an: To the : On the ba and mann	sis of examin	nowledge, deat nation and/or in	h occurred at the tin evestigation, in my o	ne, date and p pinion, death o	place, and due to the occurred at the time	cause(s , date an	s) and manner as d place, and due	stated. to the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifications and title of certifications.	4	fr	m m	9	29c. Licens		3		vary 19	
	4		30. Name and address of person	e who comp	leted orus		m 23a) (Туре, РСМ	Print) MD &	55051	lopicins	Bay	vien C	c 18CLE
89	Sta Registi		31. Date filed (Month, Day, Yea		32. Re	egistrar's Sign	nature	N.					

			1 - For State Registrar	State of Mary	land / Depa		lealth and M	lental Hygie		0170
. A	Physici /Medic Examin	cal	1. Decedent's Name (First, Middle, Last RUTH) 4a. Facility Name (If not institution, give) 1300 E, LANVA	E - CHI	AMBERS T, APT. 22	4b. City, Town, o	or Location of Death	2. Date of Death Month	Day O'ear 4c. County of Death NA	3. Time of Death
æ	Funeral Director		Usual Residence of Decedent	□M 200F 77	ýrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 1-31-26	(ear) 9. Birth Con Mo	
5-0036 72 hours after death with the Maryland	ntal Hygiene. od other than "netural; or ltems 23a or 28a-f show svent, the Madical Examiner must be notified at	by Funeral Director	Md. NA 10e. Street and Number 1300 E. Lanvale		Baltimo			10g	g. Citizen of What Cou USA	10d. Inside City Limits 1 Yas 2 No
0036 nours after deat	ural', or Items 2 I Examinar mu	d by Funera	11. Marital Status 1 □ Never Married 2 □ Married 3 ໘ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	in U.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: B	
2121 od within	Hygiene. ther than "neti ent, the Medica	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 6th grade	cation le completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of worki d)	ng	Other Peo	
arylan 2 should be	and Mer Is marke sumatic	To Be	17. Father's Name (First, Middle, Last) Unkn 19a. Informant's Name/Relationship (T)	•			Charlo	I Route Number, C	Wal.	ip Code)
ore,	of Healt fitem 2 rother		Minnie E. Jones 20a. Method of Disposition 1	Removal from State	0b. Place of Dispo	sition (Name of natory or other place	ce)	Date 20	Md. 2121 c. Location - City or T Randall1s	own, State
Dalti permit.	Department Important: f any injury o		21. signature of Funeral Service Licens 23a. Par Enter the disease, or comp	Matters	A 1	Name and Addre	. East	1101 E.	North Ave	21202 Approximate
xecuted	Wedical aminer fransit	Examiner	s' ofk, or heart failure. List only of Immen i le Cause (Final disease) or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):	0 1	oVascula		1	Interval Between Onset and Death
the death certificate	by the attending physicie tached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d	Fetal death 3 [Ectopic pregnancy	,		23d. Date of deliv	rery Day Year
requires that	been signed t should be det	by	Part II. Other significant conditions con	ntributing to death but no	t resulting in the u	nderlying cause giv	en in Part I.	23e. Did tobac	2 No 3 Pro	the cause of death? bably 4 □Unknowr
	ate has page 2	e Completed	25. Was case referred to medical	7 '	V		26. Place of Death	24a. Was an autopsy performer 1 Yes 2	prior to co	opsy findings available impletion of cause of
9 Phys	er this ieral dii	Certification: To B	examiner? 1 Yes 25 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Yea		28c. Injur Wor M 1	er: 4 Nursing Hor y at 2 k? Yes 2 No	ne 5 Pesidenc 28d. L'escribe how		
Hospital or Al	within z4 hours after deam. To the Funeral Director: After th completely filled in by the funeral	ledical Certif	4 Homicide determined 29a. Certifier Certifying Physics	28e. Place of Injury building, etc. (Sp. sician: To the best of my ner: On the basis of example:	necify) knowledge, death	occurred at the tin	ne date and place a	City or Town, S	e/s) and manner as s	stated
To the h	To the F	Medi	29b. Signature and title of certifier.	and manner stated.	S-RAME	29c. Licens			Date signed (Month,	
	Sta Registr	-	30. Name and address of person who co	t But	inou	Print) MD Role	21224			

			1 - For State Registrar	State of Ma	aryland	/ Dep	artmen rtificat	t of H e of L	lealth a	and N		giene 2	004	01705
	Physic	ian	1. Decedent's Name (First, Middle, L	.ast)							2. Date of Dea	ath Day	Yeer	3. Time of Death
	/Medi		Margaret Virg								January		004	12:01 A ^M
	Examir	ner	4a. Facility Name (If not institution, g						Location o	f Death			y of Deeth	
	·		201 Kennard A 5. Social Security Number 6.		e (In yrs. las	t hirthday	Edg If Under	EWOO	d.	24 Hrs.	8. Date of Birt		Harfo	
	Funeral Director		214-14-7027 Usual Residence of Decedent	1 □ M 2 X F	86	Yrs.	Months		Hours	Min.	Nov. 8	y, Yeer)		plece (Stete or Foreign ntry) Yland
	rylanc how		10a. State 10b. County		10c. City,	Town or Lo	ocation						7	10d. Inside City Limits
	Ba-f e	cto	Maryland Harfor	cd	Ec	dgewo	od							1 ☐ Yes 2√2 No
	with th	Director	10e. Street and Number				10f. Zip					10g. Citizen of	What Coul	ntry?
	eath ve 23g	era	201 Kennard Ave	2nue 12. Was Decedent	Euros in II C	12	Man Danne	210			- 4 . V 41	14 D-	USA	
920	72 hours after death with the Maryland nature!, or Iteme 23a or 28a-f ehow dical Examinar must be notified at	by Funeral	1 Never Married 2 Married 3 Moved 4 Divorced	Amed Forces? 1 Yes 2 If Yes, Give Year or Dates:			was Deced If Yes, spec 1 ☐ Yes 2		spanic Origin, Mexican, Specify:	in? (Sp., Puerto	ecify Yes or No- Rican, etc.)	Special Special	ce - Americ ick, White, ^{fy:} W	
2-0	n 72 hor		15. Decedent's l			16a. Dece	dent's Usua	I Occupa	ition			16b. Kind of E		
21	within 7 iene. then *r	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life.	kind of wor DO NOT us	e retired,) -		ng			
121	D 70 = -		17. Fethodo Namo (First Middle 1 -	2		Ow	ner /	Ope	rator			Boat 1		1
Maryland 21215-0036	S E S	To Be	17. Father's Name (First, Middle, Las Vernon Gresham	Corrie					Lau	ra	(First, Middle, Elizabe	eth Wh	ite	
Mar	~ ~ ~	7	19a. Informant's Name/Relationship								Il Route Numbe			
	1 an Heal em 2 ther		Nancy E. Spencer 20a. Method of Disposition	/ Daugnte		ろうろ ce of Dispo	3 AD1 sition (Naminatory or of	ngdo:	n Roa		bingdon	Mary_ 20c. Location		
5	m O		1 X Burial 2 Cremation 3 4 Donation 5 Other (Spec						1					
Baltimore,	그 등 문 등		21. Signatur of Funeral Service Lice	•	Bel	Air	Memor 2. Name and	1al d d Addres	Grains s of Facility	1-2	24-04 L ne, P.A.	Bel Air	, Ma	ryland
m	Depa Impo any i		hales (1	' amais		1	ccoma:	s fu okesi	neral bury	Hon	me, P.A. Labina	rdon Ma	וב [ייינ	nd 21009
	0 1		23a. Part 1. Enter the disease, or con shock, or heart failure. List ont	mplications that sed	the death.	Do not ent	er the mode	of dying	such as c	cardiac	or respiratory arr	est,	IL V LO	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	(ove		ascu	lan 1	You set	ider	1				Onset and Death
N	/Medical Examiner		resulting in death)	a. The last as	a consequer	nce of):	/-	0	1	1	/	-		deg
	2 A	<u>.</u>	Sequentially list conditions,	b. # The	vo Sc	dero	Le	il	dio	Na	scula	Visee	se 1	10 years
	nsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dispass of Injury	Due to (01 as	2 CONSEQUEN	ice oi):							-	
Ć,	execunation and ial-tra	Exal	that initiated events resulting in death) Last	c. Due to (or as	a consequen	nce of):								
8760,	ate be executed hysician and the burial-transit	call	(d										
Ö	ntifica ng ph as th		IE ECMAIG.											
P.O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal de	ath 3	Ectopic pre Other (spe						te of delive inth	Day Year
	law requires that the as been signed by th 2 should be detache		Part II. Other significent conditions	contributing to death bu	it not resultir	ng in the ur	nderlying ca	use give	n in Part I.		23e. Did tol	bacco use cont	ribute to th	ne cause of death?
rds	quire; on sign	ed by	Denentia.								1 🗆 Ye	es 2 No	3 Prob	ably 4 Denknown
ဝ	aw requir as been s 2 should	plet	90								24a. Wasa		Were autor	psy findings available
Œ.	The ate h page	Completed	1,4							-	autops perform	med?	death?	npletion of cause of
/ita	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	1-1-					26. Place	of Death	(Check only on		,	
of	€ ≅ ਵ	은	1 Yes 2 No	Hospital:		/Outpatien		-	4 LI Nurs		-	ence 6 🗆 Oth		9
Division	Attending F r death. ector: After by the funer	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not in		Yeer) 28	lb. Time of Injury	M 28	Bc. Injury Work' 1 Y	at ? es 2 □ N		28d. Tescribe ho	ow injury occur	red	
É	i Die		4 Homicide determined	building, etc	. (Specify)				- INCO		28f. Location (St City or Town	n, State)		
	To the Hospital within 24 hours a To the Funeral (completely filled	Medical	29a. Certifier Certifying P (Check only one)	hysician: To the best of priner: On the basis of and manner sta	examination	dge, death and/or inv	occurred a restigation,	it the time in my opi	e, date and inion, death	place, a occurre	and due to the ca ad at the time, da	ause(s) and ma ate and place,	nner as sta and due to	ated. the cause(s)
	To th Withir To th comp	Me	29b. Signature and two of Contifer				29c.	License	number		1-2	ed. Date signer	d (Month, L	Day, Year)
	n		2/////	770	TAP		1	130	907	7	, J	anunn	22	2004
	4		30 Name and address of person who	completed cause of de	ath (Item 23	а) (Туре, І	Print)		14	11	11	1	1	A. >> -
			31. Date filed (Month, Day, Year)	5 T T 73 32. Registra	132	08 14	Usine	55	en	And	This I	agen	odl	WY 21042
	Sta Registr		JAN 2 3 Z	UU4	is signature		and in							,

			Piease i	State of Maniford			-		
			1 - For State Registrar	State of Maryland	Certificate of		ental Hygiene Reg. No	4 U U I	+ 01708
			Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physici /Medi		John C	ook Jr	-1		January	19,200	4 1:10 AM
A F.	Examir	er	4a, Fecility Name (If not institution, give s	1	4b. City, Town, o	or Location of Death	40	County of Deat	h CCC
	Funeral		5. Social Security Number 6. Sex	COMMONS 7. Age (In yrs. las	t birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9, Bir	hplace (Stete or Foreign
E	Director	Н	215-09-1063	7. Aga (In yrs. las	Yrs. Months Days	Hours Min.	Almonth Day, Year	118 M	hplace (State or Foreign autry)
	w and		Usual Residence of Decedent 10a. State 10b. County	10c. City, 1	Town or Location				10d. Inside City Limits
	Marylan -f show lled at	tor	11 1 1 0 11:	nore Co	atonsvill	e			1 TYes 2 □ No
	th the or 28a e noti	lrec	10e. Street and Number		10f. Zip Code		10g. Ci	tizen of What Co	untry?
	ath wi	Funeral Director	401 Gaithe	r Ave.	212	128		USF	7
	Itame Itame	une	11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spec an, Mexican, Puerto P	cify Yes or No- lican, etc.)	14. Rece - Ame Black, White	
036	urs aff	by F	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 M No If Yes, Give Year or Dates:	1 ☐ Yes 2 No	Specify:		Specify: B	lack
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. Identity than "natural", or Itama 23a or 28a-f show od other than "natural", or Itama 23a or 28a-f show event. It a Medical Exacting trust by trutified at	Completed by	15. Decedent's Educ (Specify only highest grade	cation e completed)	16a. Decedent's Usuat Occup (Give kind of work done	during most of workin	g 16b. K	(ind of Business/	Industry
121	within ene. then '	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	ROCOVICE	Manage	2- 11	C Gni	Jernment
	filed with Hygiene. other ther	Be Co	17. Father's Name (First, Middle, Last)		newras	18. Mother's Name	(First, Middle, Maider		<u> </u>
/lan	should be filed withir and Mental Hygiene. s marked other then umatic evant, La Mi	ToB	John Cook	í Sr.		Mabe	el Coe	ρK	
Maryland	2 2 2 2		19a. Informant's Name/Relationship (Ty)	po. Print) (Wife)	19b. Mailing Address (Street	and Number or Rural	Route Number, City	or Town, State, 2	Tip Code)
	s 1 and 3 Health item 27 other tr		17/175, 17/ar/ha	20b. Plac	to 1 Gart	her HV	e Cato	ocation - City or	Town, State
mor			1 X Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State	netery, crematory or other pla	D-V 1/29/	2004 1-	Lutus	MI
Baltimore,	artn artn orts inju		21. Signature of Funeral Service Lizense	· (DID)	2. Name and Addre	ess of Facility	1 (1	Duch.	Spria.
8	Dep limp any		Joseph	a. Kuss		orth Ave.	Bulto Ma	1:2121	ما
			23a. Part 1. Enter the disease, or compliant or heart failure. List only or	cations t caus to eath.	Do not enter the mode of dying	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a c nsequer	1 S				Drowerk
)ĕ ≩	Examiner		Barana Barana Barana Barana Barana Barana Barana Barana Barana Barana Barana Barana Barana Barana Barana Baran	, Dub to (of as a ourisoquer	100 01).				
	D H	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Clause (Uneause or many that initiated events	Due to (or as a consequer	nce of):				
	xecute and al-trans	Examiner	that initiated events resulting in death) Last	Due to (or as a consequer	nce of):				
160	ficate be executed physician and is the burial-transit	caiE			,				
89	feath certificate attending physi		IF FEMALE:						
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Fetal de	eath 3 Ectopic pregnancy	y	9	23d. Date of deli	very Day Year
P.O.	that the de led by the a detached t	Physician/Medi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of deat 9□Unknown	h 5 ☐ Other (specify) _				
	The law requires that the death certifica 11e has been signed by the attending ph 2age 2 should be detached for use as th	by Pr	Part II. Other significant conditions con		ng in the underlying cause giv	en in Part I.	23e. Did tobacco	use contribute to	the cause of death?
ord	w require been sig should b	ted k	MY1	pertension			1 Tes 2	□No 3□Pr	obably 4, En Unknown
ecc	alawin nasbe e 2 sh	Completed		Hypothyrou	chsm		24a. Was an autopsy	prior to d	topsy findings available completion of cause of
a H							performed? 1 ☐ Yes 2 ☑ No	death? 1 ☐ Yes	2 ⊠ No
of Vital Records,	Physician: this certificated director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ ER	VOutpatient 3□ DOA Oth	26. Place of Death	(Check only one) e 5 Residence	E MOthor (See	nife d
		n: T	27. Manner of Death 1 ★Natural 5 Pending	1	Bb. Time of 28c. Injury Wor		3d. Describe how infu		aty)
siol	or Attanding ifter death. Diractor: After in by the fune	catic	2 Accident investigation 3 Suicide 6 Could not be		M 1 🗆	Yes 2 □ No			
Division	l or At after o Diraci	Certification:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	28	3f. Location (Street ar City or Town, State	id Number or Ru)	ral Route Number,
	To the Hospital or Attand within 24 hours after death To the Funaral Diractor: . completely filled in by the f		29a. Certifier 1 Certifying Phys	sician: To the best of my knowle	edge, death occurred at the time	me, date and place, ar	nd due to the cause(s) and manner as	stated.
×	the Hin 24 the Fu	Medical	one)	ner: On the basis of examination and manner stated.			-		
	To To	~	29b. Signature and titte of certifier	1-410 Cu Dry	29c. Licens	~ / ·		te signed (Month	
7	M		C4.00 0.	mpleted cause of death (Item 2:	3a) (Type, Print)	3642 Blud 3	Jar	1. 00	2000
	-		30. Name and address of person who co			Blud 3	05 Balt	, mre	21239
	Sta Regista		31. Date filed (Month, Day, Year) JAN 2 3 2004	32. Registrar's Signature					
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DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

2004

JAN 2 3

ORIGINAL

32

Registrar's Signature

			1 – For Registrar	State of Maryland		nt of Health and te of Death		iene 2004	01708
			Decedent's Name (First, Middle, Las	t)			2. Date of Deat	n	3. Time of Death
н	Physici		EDWARN	CLUDE	DANGE	RFIFING TR.	Month .	Day Yeer	14:15 AM
>	/Medio Examir		4e. Facility Name (If not institution, give	street and number)	4b. City	, Town, or Location of Dea	th	4c. County of Deet	1
п			2688 EAG	LE STREET		BALTIHO	ORE	NI	A
	Funeral		Social Security Number 6. Security Number	7. Age (In yrs. last	Months	r 1 Year If Under 24 Hrs Days Hours Min		Year) 9. Birt	oplace (State or Foreign untry)
н	Director	4	216-06-1424	60	Yrs.		JAN. 14,	1942 VI	RGINIA
	pue *		Usuel Residence of Decedent 10a, State 10b, County	10c. City,	Town or Location				10d. Inside City Limits
	Aaryl f sho	ō	(A Abrilla IA)	/A	ſ.	BALTIMOR	r 0. +	/	1 ⊠Yes 2 □ No
	28a-	Director	MARYLAND Number		10f. Z	DITLITION p Code		og. Citizen of What Co	untry?
	death with the Maryland ims 23s or 28s-f show		21.88 ENG	IL STORET	-	2123	12	11.5 A	,
	ms 2:	Funerai	11. Marital Status	12, Was Decedent Ever in U.S.	. 13. Was Dec	edent of Hispanic Origin? (5	Specify Yes or No-	14. Race - Ame	
0	after of the second		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ⊠Yes 2 □ No		ecify Cuban, Mexican, Puèr	to Hican, etc.)	Black, White	e, etc.
2	Durs :	l by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 🗆 Yes	2 No Specify:		Specify: B	LACK
5-0036	be filed within 72 hours after death with the Marylan Hygiene. d other than "natural", or itama 23a or 28a-f show avant, the Medical Examples must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Decedent's Usi (Give kind of w	ork done during most of wo	orking	6b. Kind of Business/	ndustry
121	vithin han han	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT			100	1
7	filed v Hygie ther t		17. Father's Name (First, Middle, Last)	LYRS 1	MAINTENA		TANT me (First, Middle, N	MD. STATE /	TIGHWAY DEPI
ang		Be c	Enula CA	DANGERFI	51N 50		1 17	+ 1	0010
Maryland	2 should and Mer is marks aumatic	2	19a. Informant's Name/Relationship			s (Street and Number or R	ral Route Number,		RRIS in Code)
<u>8</u>	train train		LOUISE DANGERF		Mora -	GLE ST.	BALTIMO		21223
ē,	E E E		20a. Method of Disposition	20b. Pla	ce of Disposition (Nametery, crematory or	me of		20c. Location - City or	
Ê	Ø 0		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Hemoval from State			26-04 0	DUDINIOS M	ILLS, MD.
	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Licen	0/1/		nd Address of Facility	ROWNJA		L HOME
ñ	E E E E		Fichol	N. Willia	~ 20,50	N. FULTON	AVE	BALTO, M	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the death.	Do not enter the mo	de of dying, such as cardia	c or respiraton arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Metastal	TE es	artice	Cance	2	Onset and Death
	/Medical		resulting in death)	Due to (or as a conseque	ence of):				
	Examiner		Sequentially list conditions.	b					
	p it	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):				
	and and I-tran	хаш	that initiated events resulting in death) Last	c. Due to (or as a conseque	ance of):	<u> </u>			
8760,	tate be executed thy sician and the burial-transit								
687	death certificate be executed e attending physician and ad for use as the burial-transi	edicai		d					
Вох	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnance				23d. Date of deli	very
ň	death a atte	icia	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea				Month	Day Year
o.	t the o	hys	9 Unknown	9□ Unknown					
o,	The law requires that the de ste has been signed by the a page 2 should be detached f	by P	Part II. Other significant conditions of	ontributing to death but not result	ting in the underlying	cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ğ	w require been sig should b	ed					1 □ Ye	s 2□No 3□Pro	bably 4 DUnknown
000	law re as be 2 sho	piet					24a. Was an	24b. Were au	topsy findings available ompletion of cause of
		Completed					perform	ed? death? ☑No 1 ☐ Yes	2□ No
Vital Records,	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?				ath (Check only one)	
<u></u>	Physic this c	P	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 El				nce 6 □Other (Spec	ify)
Ĕ	ding P h. After funera	io io	27. Manner of Death 1 Natural 5 Pending	(Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe ho	w injury occurred	
SIC	Attendi death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be			1 Yes 2 No	28f Location (Str	eet and Number or Ru	ral Route Number
Division of	al or Attendi s after death. Il Diractor: A id in by the fu	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	ie, iaiii, street, iacto	y, office	City or Town	State)	ar riodio ridilibor,
_,	pit ours fille		29a. Certifier 1 Certifying Ph	ysician: To the best of my knowl	ledge, death occurre	d at the time, date and place	e, and due to the ca	use(s) and manner as	stated.
/	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medical Exam	niner: On the basis of examination and manner stated.	on and/or investigatio	n, in my opinion, death occ	urred at the time, da	te and place, and due	to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of pertifier		29	c. License number	_	d. Date signed (Month	
	111		MILL	Lund A	10	D39127		1/22/20	04
L	141		30. Name and address of person who a A IMED 821		23a) (Type, Print)	nose MD:	21201		
	Sta	ate	31. Date filed (Month, Day Year)	32. Registrar's Signatu		The state of			
7	Regist	rar	DAM & 3 20	37	1 /1	,			

		1 - For State Registrary MFND TTFM #1 P	State of Maryland / D R PHY G828 2/10/04	epartmer	nt of Health and	Mental Hygid	ene 2004 01709
Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give s	GEORGE H. D	4b. City,	Town, or Location of De	2. Date of Death Month January	Day Year 7-20 th
Funeral Director		5. Social Security Number 170-36-8767 Usuel Residence of Decedent	M 2 F 59 Y	3	r 1 Year If Under 24 H		SAHINOVE 9. Birthplace (State or Foreign Country) 1944 Pennsylvania
Baltimore, Maryland Z1Z15-UU36 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or iteme 23a or 28a-1 show any injury or other treumatic event, the Madical Examiner must be notified at any injury or other treumatic event.	by Funeral Director	10a. State 10b. County Maryland Baltimon 10e. Street and Number 701 Edmondson		10f. Zig			10d. Inside City Limits 1 □ Yes 2 ☑ No g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-UU36 d 2 should be filed within 72 hours atler th and Mental Hygiene. 7 is marked other than "natural", or ite treumatic event, the Madical Examina	Be Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Decedent's Usu (Give kind of wo life. DO NOT u ports E	ork dane during most of vise retired) ditor 18. Mother's N	vorking lame (First, Middle, Ma	Newpaper iden Sumame)
ore, Maryla es 1 and 2 should to of Health and Ment fitem 27 is marken	To	George H. Dernoede 19a. Informant's Name/Relationship (Type Peter Dernoeden 20a. Method of Disposition	(Brother) 22	34 Dais	y Road Wood	bine, Mary	City or Town, State, Zip Code) 1 and 21797 Ic. Location - City or Town, Stete
baltimore, permit. Pages 1 ar Department of Hea importent: If item any injury or othe		1 ☑ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	Jalmote	Witzke 1630 E	nd Address of Facility Funeral Ho dmondson Av	me of Cator enue Cators	Whitemarsh, PA nsville, Inc. sville, MD 21228
S760, State of the purial-transit the burial-transit the burial-transit the purial-transit ilcai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infriated events resulting in death) Last	Due to (or as a consequence of Due to (or as a consequence of	embe	1:	esse desen	t. Approximate Interval Between Onset and Death	
UNISION OF VITAL RECONDS, P.O. BOX 68/60, To the Hospital or Attanding Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Sc. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic p 5 □ Other (s _t			23d. Date of delivery Month Day Year
equires that is sen signed by could be detailed	ted by Ph	Part II. Other significant conditions con	tributing to death but not resulting in	the underlying	cause given in Part I.		cco use contribute to the cause of death?
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DIVISION OT VI I or Attending Physici after death. Director: After this cer	ation: To B	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 ER/Outp 28a. Date of Injury (Month, Day Year) Inj		Other		ce 6 ☐Other (Specify)
UIVISION To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	Il Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	28e. Place of Injury - At home, fare building, etc. (Specify)			City or Town,	
To the Hos within 24 hc To the Fun completely f	Medical	(Check only 2 Medicel Exemirone) 29b. Signature and title of certifier	icien: To the best of my knowledge, ier: On the basis of examination and and manner stated.	or investigation	n, in my opinion, death oc c. License number	curred at the time, date	e and place, and due to the cause(s) I. Date signed (Month, Day, Year)
St Regist	ate	30. Name and address of person who co DTM DTU U (4) 31. Date filed (Month, Day, Year)	NATEM 501	Type Print)	phin st,	Balter	19 21217

	PER DVR G827 1/23/0	4 Gertificate of Dear	rh	Reg. No.
1. Decedent's Name (First, Middle, La	st)		2. Date of De Month	Day Year
ical Marie D	ixon Dill	4. Ch. T	01	08 2004 8:00
4a. Facility Name (If not institution, giv		4b. City, Town, or Location		4c. County of Death
5. Social Security Number 6.5	Sex & Remain Ct		ter 24 Hrs. 8 Date of Bir	th 9. Birthplace (State or
	1 □ M 2 13 F	Yrs. Months Days Hour	s Min. (Month, Da	y, Year) Country)
Usual Residence of Decedent				
10a. State 10b. County	10c. City, To	own or Location		10d. Inside City 1 ☐ Yes
& Md. Kent	- Che	stertown		
10e. Street and Number	P	10f. Zip Code		10g. Citizen of What Country?
10e. Street and Number 10e. Street and Number 11. Marital Status 1 Never Married 2 Marned	12. Was Decedent Ever in U.S.	21620		United States
1 Never Married 2 Marned	Armed Forces? 1 ☐ Yes 2 🛪 No	13. Was Decedent of Hispanic If Yes, specify Cuban, Mexi		Black, White, etc.
3 ⊠Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2. No Spec	ify:	Specify: White
15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ducation 16	Sa. Decedent's Usual Occupation (Give kind of work done during n	nost of working	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during n life. DO NOT use retired)	•	
Ö 17 Februar Nema (First Middle 1 as	1	clerk	other's Name (First, Middle,	Insurance
17. Father's Name (First, Middle, Last William Walte			Katherine Leo	· · · · · · · · · · · · · · · · · · ·
19a. Informant's Name/Relationship		9b. Mailing Address (Street and Nur		
Joyce Redmond/st	**	8280 Bakers Lane		
20a. Method of Disposition	20b. Place	of Disposition (Name of	Date	20c. Location - City or Town, State
1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☑ Donation 5 ☐ Other (Specia	JHemoval from State	tery, crematory or other place)		
21. Signature of Funeral Stryice Lice	- 21	22. Name and Address of Fa	CHITY 1 CEE TT	D-1-1
Manal S.	prector prector	Baltimore, MD		Baltimore Street
23a. Part1. Enter the disease, or com	plications that caused the death. D			rrest, Approximate
shock, or heart failure. List only		- 42 - 2	41111	Interval Betw Onset and D
disease or condition resulting in death)	a. CONCS THE		Julian.	Curs
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25 247 17 2 2 2 2				
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	Dharist		1. Decedent's Name (First, Middle, Last)			-			2. Date of Death Month	Day	Year	3. Time of Death
	Physicia /Medic		Eugene Ellsworth Ewing						January	17 2	004	2:00 a M
	Examin	er	4a. Facility Name (If not institution, give street and number)				Location of	f Death			inty of Deeth	
_			110F Seevue Court 5. Social Security Number 6. Sex 7. Age (In yrs. Ia	act hirthday)	If Under	1 Ai	r If Under 2	04 Hrs	9 Date of Birth		arford	
	Funeral Director		215-30-3322 1 M 2 F 69	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, Nov. 8,	1934	Goui Ma	place (State or Foreign htry) ryland
	- J		Usuel Residence of Decedent									
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M	Ba-f duffier	Director	Md. Harford		er wr							¥∏ Yes 2 □ No
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fier d	r Hear	E	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ※ No	13.	f Yes, spec	ify Cuba	n, Mexican,	Puerto F	cify Yes or No- Rican, etc.)		Black, White,	etc.
	Exam	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2	2 DONO	Specify:			Spe	_{ecity:} wh	ite
he filed within 22 hours after death with the Maryland	natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced			ation furing most	of working	10	6b. Kind o	of Business/In	dustry
d id	Man.	Jd L	Elementary/Secondary (0-12) College (1-4or 5+)	life. I	DO NOT us	e retired)		.9		-	
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9 4	ed of	Be.	Ellsworth Ewing				Juli			aluen Suri	name)	
y should	nd Me mark mati	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address	(Street a			Route Number,	City or To	wn. State. Zio	Code)
C, Ivial yie	ulth ar 27 is r trau		Margaret Woodward/Personal						allston,			,
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2 2	10 = 20		mul		610	W. M	acPha	i1 R	oad, Bel	LAir		21014
			23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	. Do not ent	er the mode	of dyin	g, such as o	cardiac or	r respiratory arre	st,		Approximate Interval Between Onset and Death
	hysician		Immediate Cause (Final disease or condition resulting in death)	ary	ar	ler	y d	se	ase			Onsoi and Doam
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ואר ביינים ביינים	death tor:	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 389 Place of Injury. At ho	me form etc	M Andrew		Yes 2□N		Of Location (Str	not and Mi	mbor or Pur	il Route Number,
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DIVISION OF A PROPERTY OF	within 24 hours after death. To the Funeral Director; A completely filled in by the formula in	edical	(Check only 2 Medical Examiner: On the basis of examinat and manner stated.	ion and/or in	vestigation,	in my or	oinion, deat	h occurre	d at the time, da	te and place	ce, and due to	the cause(s)
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	r		John W. Bowce h	70		1)0	206	49		1/20	1200	ef
	10		30. Name and address of person who completed cause of death (Item John W. Bowie, M.D., 6701 Nort			St	Ralt-	imore				
	0				ه دعد		DULL.	-more	.,			
	Sta Registr		31. Date tiled (Month, Date 12 3 20 - 32. Registrar's Signat		Selection of the select	21						

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** CHARLES JOHN **ESHTNSKY** January 20, 2004 12:15 A.M. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 3802 Walters Road Harford 8. Date of Birth (Month, Day, Year) Mar. 2, 19 If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Davs 182 M 2 □ F 88 1915 211-22-0991 Pennsylvania Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours aftar death with the Marylend nent of Heatth and Mantal Hygiana. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 X No Directo Maryland Harford Edgewood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3802 Walters Road 21040 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 200 Married tyoxYes 2 ☐ No Baltimore, Maryland 21215-0020 1 ☐ Yes 2√ENO Specify: Specify: ٥ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1940-45 White natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government 10 Machinest 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) B Tekla u/k Eshinsky John u/k Borawska 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) .00 Ethel R. Eshinsky - Wife 3802 Walters Road, Edgewood, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Grdns. 1/24/04 Bel Air, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD Part . Enlier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one or use on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner The law requiras that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home sesidence 6 Other (Specify) 1 Yes 2 No Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation d in by that 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, efc. (Specify) 4 ☐ Homicide Hospital or To the Hospital within 24 hours a To the Funeral C complataly filled edical (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 20 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 50040 01-20-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Claudia A. Kroker, MD, FACP Ce-10 Z 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 3 2004 Registrar

Eshinsky

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7	Examir	er	4a. Fecility Name (If not institution,	•	iber)		4b. City, Town, or	Location of			4c. Count	y of Death	
			1645 Ramblewood 5. Social Security Number		7. Age (In yrs. last b	inth days	If Under 1 Year	If Under 2		Date of Birth	N/		-1
	Funeral Director		217-38-1596	1□M 2∏F	63	Yrs.	Months Days	Hours	Min.	B. Date of Birth (Month, Day, UQUST 31	Year)	Coul	plece (Stete or Foreign ntry)
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	within 72 hours after death with the Maryland ene. then "natural", or Items 23s or 28s-1 show the Medical Examinat Frank be tealthed at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	Armed For	dent Ever in U.S. ces? 2 TWNo	13.	Was Decedent of Hi f Yes, specify Cuba	n, Mexican,	Puerto Ri	can, etc.)		ce - Ameri ck, White,	
21215-0036	ars af	þ	3 Widowed 4 Divorced	If Yes, Give Year or Da	9		1 ☐ Yes 2 ☐ No	Specify:			Speci	∜: Whi	te
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Maryland			19a. Informant's Name/Relationshi Lyon Fisher - So				ng Address (Street a Outh George				-		*
	1 and Health em 27		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of		Dilve		Oc. Location		
Baltimore,	permit. Pages : Department of H Importent: If Ite eny injury or ot		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		state cemete	өгу, сгөг	natory or other place		100 104				
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Вох	atter atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1☐Live bi	rth 2 Fetal deat ant at time of death		Ectopic pregnancy Other (specify)					onth	Day Year
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of V	Physic this ce al dire	2	1 XYes 2 □ No		patient 2 ER/O	utpatien	t 3 DOA Othe	r: 4 🗆 Nurs	sing Home	5 🗆 Reside	nce 6XIOti	ner <i>(Specif</i>	w at scene
Ē	ding Ph h. Alter th funeral	 	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date o (Month	f Injury 28b. n, Day Year)	Time of injury	Work	?		d. Describe ho	w injury occur	rred	
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Division	after of Dirac	Certification:	4 Homicide determin	286. Place	of Injury - At home, f g, etc. <i>(Specify)</i>	rarm, str	eet, factory, office		28	City or Town,	eet and Numi State)	ber or Hura	I Route Number,
Lai	pital ours a naral l		29a. Certifier 1 ☐ Certifying	Physician: To the	best of my knowledg	ne death	occurred at the tim	e date and	place, an	d due to the ca	uso(s) and m	22222	totod
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: Alter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be delached for use as the burial-transit	Medical		xeminer: On the ba and mann	sis of examination a	nd/or in	estigation, in my op	inion, death	occurred	at the time, da	te and place,	and due to	the cause(s)
	To the within Fo the	Me	29b. Signature and title of certifier				29c. License	number		29	d. Date signe	ed (Month,	Day, Year)
	1		I him hi	. m.D			OCME			J	anuary	19 2	2004
	X		30. Name and address of person w		of death (item 23a)	(Туре,	Print)						-3.01001
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恋	Sta		31. Date filed (Month, Day, Year)	32. Re	gistrar's Signature		1. 9	ald.					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 State Amend Item 26 per verb., G82701/23/04 Deptificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Dorothy 15, 20043:00 P.M Fisher January /Medical 4e. Fecility Neme (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner Sinai Hospital Baltimore N/A| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 26, 1923 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Maryland Director 80 Usuel Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r then "natural", or items 23s or 28s-f ehow the Medical Examiner must be notified at Yes 2□No Funeral Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2095 Rock Rose Avenue 21211 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 25 No Specify: þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own Home permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If Item 27 is marked othe
eny injury or other traumatic event,
since. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jessie E. Smith Annie E. Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Floyd Smith 1720 Woodstock Road Woodstock, Maryland 21163 Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

■ Burial 2 □ Cremation 3 □ Removal from State * 4 □ Denation 5 □ Other (Specify) Baltimore National 1/20/2004 Baltimore, Maryland 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc
3631 Falls Road, Baltimore, Maryland 21. Signature of Funeral Service Lice 23a. Pert I Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ovensin Physician /Medical Due to (or as a consequence of) Examiner Semle Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed Cardio- Pulmonan the attending physician and hed for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ☐Yes 2 No detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2X No 2. No 1 TYes 1 Yes Be 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🔀 No 1 Inpatient 2 X ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funeraf 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 030115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANG 2600 LIBETY HCITS Belt more mo 2/215 410 KPRHSI, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2 3 2004 DHMH 17 Rev 1/2001

	Physici /Medic Examir		1- For State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death Reg. No.								4 017	16	
nui			1. Decedent's Name (First, Middle, Last) Tuanita Frunce				2. Date of DeathMonth D				Yea 21,280	3. Time of De	ath A M
		ner	4a. Facility Name (If not institution, give street and number) Tohns Hopkins Bayrien Care Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)				4b. City, Town, or Location of Death Baltim & re If Under 1 Year If Under 24 Hrs. 8, Date of Birth				4c. County of Death N/A		
2.0	Funeral Director		412-10-8504 Usual Residence of Decedent	1 ☐ M 2 ☐ XF	82	Yrs.	Months Days		Aug. 1	ay, Year)	, (irthplace (State or Fo Country) nnessee	ireign
	he Maryland 8a-f show	Completed by Funeral Director	Maryland N/A			ty, Town or Lo ltimore	City					10d. Inside City L 1 Yes 2	
	with the		10e. Street and Number 1510 Ramsey St	24422				tizen of What (Country?				
36	rs after death I', or Itema 2: xaminer mu		11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deced Armed Ford	es? .⊠No	1		dispanic Origin? an, Mexican, Pu	(Specify Yes or No lento Rican, etc.)	- US		nerican Indian, lite, etc. White	
215-0036	should be filed within 72 hours atter death with the Maryland and Mental Hygiene. s marked other than "natural", or itema 23e or 28e-f show unmatic event. If a Medical Examinat must be notified at		15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education		(Give	tent's Usual Occup kind of work done DO NOT use retire	during most of v	working	16b. K	ind of Busines		
e, Maryland 2121			12		101 3+)	Sh	irt Pres				ufactu	rer	
		To Be	17. Father's Name (First, Middle, L Driscoll E	dward	Stepp			18. Mother's N	Name <i>(First, Middl</i> e,		,	II 1 -	
		F	19a. Informant's Name/Relationshi		оссрр	19b. Marlin	g Address (Street		Rural Route Numbe		abeth or Town, State,	Harriso	on
	s 1 and 2 f Health item 27 i	0	Hattie E. Stepp	(Sister i	n Law)	5700	Carringt	on Dr.,					
	m 0		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation		210	emetery, cren	sition (Name of natory or other plan rk Cemete		Date / 2.4. / 0.4.		ocation - City o		
altin	permit. Page Deportment Importent: If any njury or	1	4 ☐ Donation 5 ☐ Other (Sp.21. Signature of Funeral Service Li		, nou		. Name and Addre		/24/04	_		Maryland	L
ñ	Dep Impo	1	Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229										
s, P.O. Box 68/60,	To the Hospitel or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit on property.	16	23a. Part: Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	nry one cause on eac	or the death of the line. If the line is a consequence of the line is a c	h. Do not ente	er the mode of dyin	ng, such as card	liac or respiratory ai	rrest,		Approximate Interval Between Onset and Deat	
			Sequentially list conditions	b. $\frac{HVP}{Uu^2}$ to (or								MINUTES	
		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		c. RESPIRATORY FAILURE Due to (or as a consequence of):							MONTHS	
		dicai			a CHRONIC OBSTRUCTIVE PULMUNA					ARY DISEASE			
		by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Mono 9 ☐ Unknown							2	23d. Date of delivery Month Day Year		
			Part II. Other significant condition						23e. Did to	obacco u	se contribute t	o the cause of death	?
cora		eted	Theumonia, C CEREBROVASCI	ORONARY	ARTER	y D15	EASE,		- 1 /X (Y		□No 3□P	robably 4 □Unkn	own
al Hec		Completed by	EXTRENITY						1□ Yes	rmed? 2 MNo		utopsy findings avail completion of cause 2 No	
ion of Vital		To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Mino	atient 2	ER/Outpatient	3□ DOA Oth		eath (Check only of		COther (Co.	10/4 d	_
			27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	e of 28c. Injury at 28d. Describe how Work? M 1 Yes 2 No			escribe how injury occurred						
DIVISION		Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)				Street and m. State)	eet and Number or Rural Route Number, State)					
		Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
N.		2	29b. Signature and title of certifier	29c. License number 29d. Date signed (-					
	V		30. Name and address of person wh	no completed cause of	of death (Item	23a) (Type, P	Print)	124	3	- 100	-n-y2	1,2004	
			William Greens	ugh	5505	HOPK	INS BAYN	IEN CIR	CLE BAL	MADE	E MD	21224	
	Sta Registra		31. Date filed (Month, Day, Year)	32. Reg	strar's Signat	9 A	parker						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1 tem 8 per fh 9845 7-15-05 vt State of Maryland 7 Department of Health and Mental Hygiene 2 0 0 1 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month January 20, 2004**Physician** Rita Anna Fox 8:34A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11820 Gontrum Road Kingsville Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthptece (State or Foreign 8. Date of Birth (Month, Day, Yeer) **Funeral** Mary Land 1 ☐ M 2 🗓 F 75 216-24-2459 Director May 4, 1928 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow other traumatic event, the Madical Examiner must be notified at MD Baltimore 1 ☐ Yes 2√2 No Director Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11820 Gontrum Road 21087 United STates or Itams 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. filed within 72 hours after of Hygiene.

Hygiene.

Nher than "natural; or Ital 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo þ Specify: White 3 Widowed 4 Divorced ear or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If item 27 is marked other th any injury or other traumatic event. Ih-Telephone Operator AT&T 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Julius Weiss Barbara Anna Huber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard Fox (Husband) 11820 Gontrum Road Kingsville, Maryland 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem 1/23/04 Baltimore, Maryland 21. Signature/of Funeral Service Licensee Miller-Dippel Funeral Home, INc. Ceralieth Se 6415 Belair Road Baltimore, Maryland 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** embrounselar disense disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Doe to (or as a consequence of) Examiner the attending physicien and The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ♣ No 24a. Was an has autopsy performed? certificate 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Other: 4 Nursing Home Sesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

To the Hospital or Attending Physician: ۲ this After death.

in by the funeral Certification: Director: hours after within 24 hours a To the Funeral

1 ☐ Yes 2 No 27. Manner of Death

Natural 5 Pending investigation 2 Accident 3 Suicide 4 Thomicide

6 ☐ Could not be determined

28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29a. Certifier

DZC673 1/21/04 ROM : BITCTITUM, M) 21236 o completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

31. Date filed (Month

JAN 23

28a. Date of Injury (Month, Day Year)

		For State Registrar	State o	f Marylar		artment o			Mental Hy	giene Reg. No.	2004	01718
Dhysiair		1. Decedent's Name (First, Middle		1		L.			2. Date of De Month	Day	Year	3. Time of Death
Physicia /Medic		Catherine		obline	horsi				Januar			
Examin	er	4a. Facility Name (If not institution			0 -	4b. City, Tov	vn, or Local	- 1		40.0	County of Dea	MORE
		NorthwesT 5. Social Security Number	HOSPITa 6. Sex	7. Age (In yrs.		If Under 1 Y		nder 24 Hr		rth .	9. Bi	rthplace (State or Foreign
Funeral Director		212-22-0837	1 □ M 2 🕦 F	72	Yrs.	Months D	ays Hou	urs Mir	09-10-	1926		uryland
g ,		Usual Residence of Decedent 10a. State 10b. County		10c Cit	ty, Town or Lo	ocation						10d. Inside City Limits
shov	5											1 ☐ Yes 2 ⊋No
the N 28a-i	rect	Md Balti 10e. Street and Number	more	K	anda11	10f. Zip Co	de			10g. Citiz	en of What C	ountry?
h with	Funeral Director	3434 Abbie Pla	ce			212	244			U.	S.A.	
deati	ner	11. Marital Status		edent Ever in U	.s. 13.	Was Decedent	of Hispanio	c Origin? (xican, Pue	Specify Yes or No rto Rican, etc.)	D- 1-	4. Race - Am Black, Whi	erican Indian, ite, etc.
-0036 hours after death with the Maryland tural', or ttems 23a or 28a-f show at Exactiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	ried 1 ☐ Yes If Yes, Gi	2 No		1 ☐ Yes 2 🔀		ecify:			Specify Wh i	
	ed b		Year or D	ates:	16a. Dece	dent's Usual C	ccupation			16b. Kin	d of Business	s/Industry
vithin 72 ene. then "nat	Completed	(Specify only highe: Elementary/Secondary (0-12)	st grade completed) College (1-4or 5+)	(Give	kind of work of DO NOT use r	lone during etired)	most of w	orking			
212 212 3d with giene.	E	07	Oonoge (Wa	itress					od Ser	vice
tnd 2 be filed ttal Hygi td other	Be (17. Father's Name (First, Middle,							ame (First, Middle		iumame)	
	မ	Frank J. Gross			10h Mailie	Addraga /C			Mary Mar		Town State	Zin Code)
Mar nd 2 sho lith and 27 Is m		19a. Informant's Name/Relations Rosemary Schro				-			rs,Pa 17		rown, State,	Zip Gode)
		20a. Method of Disposition		20b. F	Place of Dispo	osition (Name of matory or other	of rolana)	1	Date	20c. Loc	ation - City o	r Town, State
		1 ■ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		State		f Fait		01-	23-2004	Ba1	timore	
Baltimore, permit. Pages 1 ar Department of Hea Important: If item any injury or other		21. Signature of Juneral Service		1,								Directors Invland 21133
box 68/60, death certificate be executed Examined the executed Box 100 and Cor use as the burial-transit	lical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, 1 arry, teading to immediate cause. Enter Underlying Cause (Disease or injury that infixated events resulting in death) Last	a. Acu Due to b. Due to c. Non	(or as a consection of the con	pirate		can	e				Interval Between Onset and Death 12. hours > 12 hours > 2 years
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ecords, P.O law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions Coronary arts	1		sulting in the u	inderlying caus	e given in F	Part I.	1	tobacco us Yes 2□		o the cause of death?
~ o = 0	Completed by	Hypertension	1.	1	. l.				24a. Was auto perfe		prior to death?	utopsy findings available completion of cause of
VITAL RO ician: The l certificate ha ector, page	BeC	Chronic obstru 25. Was case referred to medica		imonar	y also	ease	26. F	Place of De	1 ☐ Yes eath (Check only		10,16	20110
VISION Of VITA Attending Physician: or death. ector: Atter this certifica by the funeral director.	10 E	examiner? 1 ☐ Yes 2 M No			ER/Outpatier	nt 3 DOA	Trible and the	Nursing	Home 5 ☐ Res	_		ecify)
on of ding Ph h. After thi funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pendir	28a. Date (Mor	of Injury hth, Day Year)	28b. Time of Injury		Injury at Work?	2 CN-	28d. Describe	how injury	occurred	
SIO teath. tor: A	cati	2.☐ Accident investi 3 ☐ Suicide 6 ☐ Could	not be	of Injury - At h	omo form otr	M root factory of	1 ☐ Yes	2 🗆 No	28f Location (Street and	Number or F	lural Route Number,
Division of Vital or Attall or Attending Physicien: 7 efter death. Director: Atter this certifical in by the funeral director, p	Certification:	4 ☐ Homicide determ	nined 200. Flact	ing, etc. (Special	fy)	reet, lactory, o	1100		City or To			
DIVISION To the Hospitel or Attendin within 24 hours efter death. To the Funerel Director: Att completely filled in by the fur		29a. Certifier 1 Certifyin	ng Physicien: To the	e best of my kno	owledge, deat	h occurred at t	he time, da	te and place	ce, and due to the	cause(s) a	nd manner a	s stated.
he Ho n 24 t he Fu pletely	Medical	(Check only 2 Medical one)	Examiner: On the band man	asis of examination and stated.	ation and/or in				curred at the time,			
withi To t	≊	29b. Signature and title of certifie					284	_				th, Day, Year)
\		> & Boston	- •									3, 2004
V		30. Name and address of person J Boston 1	vorthwes	se of death (Iter	ital	Center	Rand	dalls	stown	Mar	yland	21133
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J Boston Northwest Hospital Center Randallstown Maryland 21133 State Registrar 31. Date filed (Month, Day, Year) 2 3 2004 32. Registrar's Signature (Month) 33. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leading Type, Print) J Boston Northwest Hospital Center Randallstown Maryland 21133								<u> </u>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. HONG GUO State of Maryland / Department of Health and Mental Hygiene ? 04-00166 UNK 04-009 Certificate of Death DAP 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY 7,2004 **Physician** 12:55a M HONG **GUO** /Medical 4e. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 6304 EASTERN AVENUE BALTIMORE CITY 7. Age (In yrs. last birthday) 39 Yrs. If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 🐰 🖺 F 3/1/1964 Director CHINA UNKNOWN Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show the Medical Examiner must be notified at 1 XXes 2 □ No BALTIMORE CITY Director MD or 28e-1 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 21224 23a 6304 EASTERN AVENUE by Funerai death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. fited within 72 hours after 1 ☐ Yes 2**X X**No If Yes, Give Year or Dates: 1 ☐ Never Married X 2 ☐ Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes ZXNo Specify: ASIAN 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry l Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) COMPUTER CONSTRUCTION CO. other other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fit I Health and Mental H item 27 is marked off Be ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) t of Health a XIN MIN WU - HUSBAND 65 RIVINGTON ST., APT. 7, NEW YORK, NY 10002 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Pages 1 Burial 2XX remation XX Removal from State ŏ permit. Page Department of Important: If eny injury or once. GREENWOOD CREMATORY 1/17/2004 * 4 ☐ Donation 5 ☐ Other (Specify) Brooklyn, NY 21. Signate Funeral Service

22. Name and Address of Facility FINK FUNERAL

RELLY GREGORY FINK #M01148

23a. Part 1. Enter the dispasse of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility FINK FUNERAL HOME, PA 426 CRAIN HWY., S, GLEN BURNIE, MD 21061 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 00 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the control of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, Physician/Medicai as the attending I for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached O. ÌВ 9 Unknown 9 Onknown δ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ ed bluods 2 No 1 Tyes 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No page 2 autopsy performed? Yes 2 No in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \nearrow Other (Specify)AT SCENE 10 1 √Yes 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division To the Hospitel or Attending 5 Pending investigation 1 Natural Injury 8Tha 1 NE death. s after death. 2 Accident 6 Could not be determined 3 Sujcide 28e. Place of Injury - At hom, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or City or Town, State) Rural Route Number 4 Tomicide 0 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai

State Registrar

within 2

31. Date filed (Month, Day, Year) JAN 2 3 2004

and address of person Afo

ause of death (Nem 23a) (Type, Print)
111 Penn Street, Baltimore, Maryland 21201 Wille, M 32. Registrar's Signature

29c. License number

OCME

29d. Date signed (Month, Day, Year) JANUARY 7,2004

29b. Signature 1

			For State Registrar	State of Mary		artment of rtificate o		R	eg. No.	04 01720
	Physici		Decedent's Name (First, Middle, Last Mary Gorman					2. Date of Deat Month January	Day Ye	3. Time of Death 8:45 PM M
	/Medic Examin		4a. Facility Name (If not institution, give 12299 Dixie Dri	street and number)		4b. City, Town	oville		4c. County of t	Death
1	Funeral Director		5. Social Security Number 6. Se 218-18-6786	x 7. Age (In	yrs. last birthday) 8 Yrs.	If Under 1 Ye Months Day	ar If Under 24	Hrs. 8. Date of Birth Min. (Month, Day, Sept II		Birtholace (Stete or Foreign Country) 1ary Land
	the Maryland 28a-f show	Director	Usual Residence of Decedent		c. City, Town or Lo	opville	9	1	0g. Citizen of Wha	10d. Inside City Limits 1 ☐ Yes 2√☐ No
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at ODGE.	by Funeral DI	12299 Dixie Drive 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			21813 of Hispanic Origin Juban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	Black, \	American Indian, White, etc. White
00-61212	I within 72 hou iene. r then "nature r medical E	Completed I	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ıcation	(Give	dent's Usual Oc kind of work do DO NOT use rel cashier	ne during most of ired)	working	16b. Kind of Busin	
Ē	should be filed ind Mental Hyg marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) Charles B. gorma 19a. Informant's Name/Relationship (7)		19b. Maili	na Address (Stre	Mar	Name (First, Middle, I y Belle Do r Rural Route Number	Maiden Sumame) TSEY	
Baitimore, Ma	ages 1 and 2 s ent of Health an it: If Item 27 is i y or other traui		Mary Abell/daugl 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	nter	1229 Ob. Place of Dispo	9 Dixie	Drive B	ishopville		813
Baltir	permit. P Departme Importan eny injur		21. Signatur of Funeral Project Licens	Wall Direc	В	altimore	MD 21			
	Pnysician /Medical Examiner		23a. Part \ Enter the disease, or comp shock, "pheart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a co	late L	- Ucg	Come		est,	Approximate Interval Between Onset and Death
8/60,	sate be executed obysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitated events resulting in death) Last	Due to (or as a co						
O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregna □ Other (specify			23d. Date o Month	f delivery Day Year
1	w requires that been signed b should be deta		Part II. Other significant conditions of	entributing to death but no	ot resulting in the u	inderlying cause	given in Part I.			te to the cause of death? Probably 4 Ninknown
al Records,	ician: The law re certificate has bee rector, page 2 sho	Completed						24a. Was a autops perform	ned? dea 2 Alo 1 □	re autopsy findings available r to completion of cause of th? Yes 2 \sum No
on of Vital	ing Phys After this uneral di	tlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Watural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatier 28b. Time o	of 28c.	26. Place of Other: 4 Nursin Nury at Nork?		ence 6 Other ((Specify)
Division	Hospital or Attendi 24 hours after death 5-uneral Director: A e ely filled in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc. (S	Specify)			City or Town	n, State)	or Rural Route Number,
	To the riospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical		vsicien: To the best of m iner: On the basis of exa and manner stated	amination and/or in	nvestigation, in n		occurred at the time, d		due to the cause(s)
	Sta Regist	ate	30. Name and addre s of person who a	Goroduli 32. Registrar's	ice w	Print) /3	209 C	ousted to	togh cy	19944

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of M	arylan		artment of I			F	Reg. No.	COL	0172
i	Physicia /Medic		1. Decedent's Name (First, Middle	Last)		Ga	lek			Date of Dea Month	Dey	Yeer 2004	3. Time of Death
	Examin		4a. Fecility Name (If not institution,	Kin3 He	O O	last birthday)	4b City, Town, o	MQ If Under	Re	. Date of Birtl		ty of Death	lece (Stete or Foreign
Ė	Funeral Director		217-38-4363 Usuel Residence of Decedent	V	52	Yrs.	Months Days	Hours	Min. J	Date of Birtl (Month, Day une 2,	1941	Mary	try)
	ne Maryland 8a-f show	Director	10a. State 10b. County Maryland N/	A	10c. Cit	y, Town or Lo	Baltimo	re Cit	ty		10g. Citizen of		Od. Inside City Limits IN☐ Yes 2☐ No
	h with t	al Dir	10e. Street and Number 132 North Rose	Street			10f. Zip Code 212	24			U.S.		iu y r
036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show imatic event, it a Medical Examinating the rigidial at	by Funeral	11. Marital Status 1 □ Never Married 2 → Marri 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? ad 1 Yes 24 If Yes, Give Year or Dates:			Was Decedent of If Yes, specify Cub			y Yes or No- can, etc.)	Bla	ace - Americ ack, White, ify: whi	etc.
Maryland 21215-0036	I within 72 ho lene. r than "natur Ina Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)		5+)	(Give life.	dent's Usual Occu kind of work done DO NOT use retire e keeper	during mos	at of working		Bureau City o	of Pi	urchasing-
yland	d ta b	To Be C	17. Father's Name (First, Middle, I Joseph Galek 19a. Informant's Name/Relationsh			10h Mailie	ng Address (Stree	E1a	aine C	arlis1			Code
	and 2 st ealth and n 27 is n		Eugene J. Galek				Knell Av						
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		20b. F	Place of Dispo cemetery, cres dlawn	sition (Name of matory or other pla Cemetery	ісе)]	Dat 1/23/2		20c. Location Woodla		own, State aryland
Baltir	permit. P Departme Importan any injur		21. Signature of Funeral Service				2. Name and Addr			les S.	Zeile	r & So	on, Inc.
A.	Physician /Medical Examiner	Iner	23a. Part I Enter the disease, or short, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Lisease or injury that initiated events		str a conseq	h. Do not ent	224 Easte er the mode of dy Cancer	ng, such as	cardiac or r	espiratory ar	rest,	aryran 	Approximate Interval Batween Onset and Death
. 68760,	rtificate be executed ng physician and as the burial-transit	Medical Examiner	Cause (Desage of Mury that initiated events resulting in death) Last	cDue to (or as	a conseq	uence of):							
.O. Box	The law requires that the death certifica tie has been signed by the attending ph tage 2 should be detached for use as th	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 🗌 Feta	ıldeath 3[Ectopic pregnand Other (specify)	;y				ate of delive Month	ory Day Year
Q .	w requires that been signed b should be deta		Part II. Other significant condition	ns contributing to death I	out not res	ulting in the u	nderlying cause g	ven in Part I	l.	•	obacco use col		ne cause of death?
Vital Records,		Completed								1 ☐ Yes	rmed? 2 D No	. Were auto prior to con death? 1 Yes	psy findings available impletion of cause of
	Physicien: this certific al director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2	ER/Outpatier	nt 3 DOA O			Check only o	<i>ne)</i> dence 6 □O	ther (Specifi	y)
Division of	Attending Physicien: If death. Cotor: After this certific by the funeral director,	atlon: T	27. Manne of Death 1 Natural 5 Pendin 2 Accident investig	28a. Date of Inj g (Month, Da jation	ury	28b. Time o Injury	f 28c. Inju Wo		28		now injury occu		
Divis	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could a determined	building, e	tc. (Speci	fy)	reet, factory, office	W		City or Tou	vn, State)		d Route Number,
	Hospitel or 24 hours afte Funeral Dir etely filled in	edical	29a. Certifier Tertifyin (Check only 2 Medical one)	g Physician: To the best Examiner: On the basis of and manner s	of examina	owledge, deat ation and/or in	h occurred at the t vestigation, in my	ime, date ar opinion, dea	nd place, an ath occurred	d due to the d at the time,	cause(s) and n date and place	nanner as si e, and due to	tated. the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifie	•				se number			29d. Date sign	ned (Month,	Day, Year)
)			The step	M			RES	5-0	00		Januar	ry 19	2004
	4	1 33	50. Name of address of person	100 D	death (Ite	m 23a) (Type,	Print) N. Wolf	e St	Bal	Himor	e m	D 2	1287
	Sta Regist		31. Date filed (Month, Day, Year)	2. Regist	rar's Sign	ature 🎤	te						

04-00637 B.K.S EDWARD J. HOLLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma			nent of H cate of L			giene 2 (Reg. No.	104	01722
	Physici	20	1. Decedent's Name (First, Middle, La						2. Date of De Month	Day	Year	3. Time of Death
	/Medic		Edward J. Hollar						JAN.	22, 20		1₀2:35 P ^M
	Examir	er	4a. Facility Name (If not institution, given 524 NORTH CHARLE		\DT 212	4b.		Location of Deat		N/A	y of Death	
	Funeral		5. Social Security Number 6. S		e (In yrs. last birt	140	Under 1 Year onths Days	If Under 24 Hrs Hours Min	8. Date of Bir	th y, Year)	9. Birthp Cour	olece (State or Foreign htry)
	Director		215-22-3636 Usual Residence of Decedent						Jun 24	, 1927	MID	
	ahow		10a, State 10b. County		10c. City, Town	or Locatio	on				1	0d. Inside City Limits
	Ba-fa	Director	MD N/A		Balti	more						1 12 Yes 2 □ No
	or 28	Dire	10e. Street and Number			11	Of. Zip Code			10g. Citizen of		-
	a 23a	erai	524 N. Charles S	treet, Apt		12 14/25	21201	connic Origin? (9	Specify Ven or No	United	ce - Americ	
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23s or 28s-1 show any injury or other treumatic event, the Medical Exattrian could be notified at Once.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Nidowed 4 Divorced	Armed Porces? 1 Dres 2 1 If Yes, Give Year or Dates:	WWII		yes 25 No	Specify:	Specify Yes or No to Rican, etc.)	Speci	ack, White,	etc.
9	72 ho	ted	15. Decedent's E (Specify only highest gr	ducation		Decedent's	s Usual Occupa	ation furing most of wo	rking	16b. Kind of 8		
Maryland 21215-0036	within 7 ene. than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5		life. DO N	VOT use retired)	, King	City c	of Bal	timore
2	filed with Hygiene. other than		12 17. Father's Name (First, Middle, Las	')	Mc	inte	nance	18. Mother's Na	me (First, Middle,	Maiden Suma	me)	
an	should be nd Mental marked o	To Be	Edward Jerome H						Elizabeth			
ary	should be and Mental la marked o		19a. Informant's Name/Relationship		19b.	Mailing Ad	ddress (Street a		ural Route Numbe			Code)
	1 and 2 Health a lem 27 la		Mrs. Gloria C. 1	errell/Sis					onsville			
ore	Pages 1 nent of Hi int: If iter iry or oth		20a. Method of Disposition 1 Burial 2 Oremation 3	Removal from State	20b. Place of cemeter	Disposition y, cremator	n (Name of ry or other plac	9)	Jan 23	20c. Location	- City or To	own, State
Baltimore,	permit. Pag Department Important: I any injury o		* 4 □Donation 5 □ Other (Special Service)*Lice				e Crema		2004	Beltsv	ille,	MD
Ba	permit. Departn Imports any inju		18 Ha	lell-	mp0886	Cr 87	emation 17 Gree	n and Fu en Pastu	neral Al res Driv	e Balt	ves imore	
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	one cause on each li	ne.							Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a other	a consequence of		Card	iovasc	ulard	15805	e	
	Examiner			·	a consequence o	и):						
3	P it	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of	of):						
	cate be executed physicien and the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as	a consequence of	of):						
68760,	sicien buria	alE		d		,-						
687	ificate g phys	edical		d								
XO	death certifii attending I I for use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth	of pregnancy 2 Fetal death	3 □Ecto	opic pregnancy				ate of delive	
O. B	The law requires that the death certificate be executed tte has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown	4□Pregnant at 9□ Unknown	time of death		ner (specify)			M	onth	Day Year
P.0	res that the deigned by the		Part II. Other significant conditions	contributing to death b	ut not resulting in	the under	lying cause give	en in Part I.	23e. Did t	obacco use cor	ntribute to th	ne cause of death?
Records,	quires in sign	ed by						*	10	res 2□No	3 Prob	ably 4 Unknown
000	aw requir ss been si 2 should I	Completed							24a. Was			psy findings available mpletion of cause of
	(0 ===	Com							perfo	rmed?	death?	
/ita	cian: ertific ector,	Be	25. Was case referred to medical examiner?	Lia anitali			04		ath (Check only o	nne)		
of Vital	Physician: this certific ral director,	To T	27. Manner of Death	Hospital: 1 Inpatie	ent 2 ER/Out		DOA Othe	4 Nursing r	dome 5 Resident			AT SCENE
	ding h. After funer	tion	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 2 Accident investigation 28a. Date of Injury 28b. Time of 28c. Injury at Work? 1 Yes 2 No							iow injury occu	1160	
Division	l or Attending after death. Director: Afte in by the fune	Certification:	3 Suicide 6 Could not l	28e. Place of Inj	ury - At home, fai	rm, street,	factory, office		28f. Location (: City or Tox	Street and Num	ber or Rura	I Route Number,
Ö	itel or A rs after al Directed in by	Cert	4 - Homelde	Daliding, et	c. (Specify)				Chy or 70	wn, State)		
4	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical		hysician: To the best miner: On the basis o and manner st	f examination and							
	To the within 2 To the comple	Me	29b. Signature and title of certifier	\	DM.		29c. License			29d. Date sign		•
	111		Matrice	imica	-tolle		0.C.	M.E.		JAN.	22,	2004
	51		Name and address of person who	completed sause of c	leath (Item 23a) (Ral+im	ore, Mary	r back	1201	
5	* Sta	ite	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	1		DOTTIN	re, nar	улани 2	1201	
	Regist		10 N O O 2004	havera	D	Spar	Krl					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Wayne Harkleroad 2004 Carl January 20, 3:21 P /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Medical Ctr. Baltimore City N/AIf Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 J⋅M 2 □ F 414-34-7911 75 Aug. 25,1928 Tennessee Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County rai', or items 23a or 28a-f ahov Examiner must be notified at Dundalk 1 Yes 2 No Maryland Baltimore Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21222 United States 2011 Inverton Road Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced White Korean "natural" er than "natural i 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) tat Hygiene. od other than event, the M Elementary/Secondary (0-12) 11 Years Millwright Steel Industry 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be 27 is marked or traumatic ev Nola Anderson John Harkleroad 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 3
Department of Health ar
Important: If Item 27 is
any injury or other trau 2011 Inverton Road Dundalk, Maryland Mrs. Mary Sue Harkleroad (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 St Cremation 3 ☐ Removal from State Hilltop Service Corp. 1/23/2004 Towson, Maryland 4 □Donation, 5 □ Other (Specify) 21. Signatur Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk,
7922 Wise Ave. Dundalk, Maryland Regon Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Acute RESPIRATORY FAILURE
to (or as a consequence of):
Chronic Obstructure Luny Disease Immediate Cause (Final disease or condition Physician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): burial-t ed by the attending physician detached for use as the burial P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe this certificate 1 Yes 20 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 1 ☐ Yes 2 XNo Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide in by t filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 01/22/2004 D 6021859. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOHAMMAD TARIMD 23 SHIPPING Pl Baltimore MD 21222 32. Registrar's gnature 31. Date filed (Month, Day, Year) Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death Year **Physician** HUGHES WILLIAM 2004 10 JAN 02:50 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Genesis Elder Care Randallstown Baltimore If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) **Funeral №** M 2□ F Months Days Yrs. 51 Director 215-58-4144 Usual Residence of Decedent 27 MD permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Merylend Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f ahow any injury or other traumatic event, the Medical Examinat must be notified at pince. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits YXYes 2□No Director MD Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 3606 Spaulding 21215 Ave Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: Black á 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 2yrs 12th grade Cashier College 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Surnama) Be William Buddy Hughes Doris McMillion 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 426 North Robinson Street, Balto, Md 21224 Tanya Hughes-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 1/23/04 Randallstown, Md 21. Signature of Funeral Service Lices 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore Md 21215 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical CONGESTIVE MEDARY Examiner Due to (or es e consequence of): Physician/Medical Examiner DAY ARTERI DISEASE CORONARY Attending Physician: The lew requires that the death certificate be executed ig physician and as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part t. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical å 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 | Yes 2 | No 28a. Date of tnjury (Month, Day Year) 28c. Injury at Work? ar deeth. 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation after deeth Director: A d in by the f 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide ò To the Hospital o within 24 hours of To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD JAN 22nd 2004 upha 00053150 BALTIMORE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201-109 BACURWER NECLICO PTAMD Sh ALEUNM ACA CU 32. Registrar's Signature 31. Dete filed (Month, Day, Year) State Registrar

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		1 - For State Registrar	Oldio of Mic		ertificate of			Reg. No.	JU4	01/25
Physic	rian	Decedent's Name (First, Middle, La	-				2. Date of Dea	ath Day	Year	3. Time of Death
/Med		RAYMOND JOSEPH					January	19, 2	004 1	2:01 A M
Exam	iner	4a. Facility Name (If not institution, give	e street and number)			or Location of Dea	ath	4c. County		
Funera		56 Anchor Way 5. Social Security Number 6. 8	Sex 7. Age	(In yrs. last birthda		If Under 24 Hi			cester	
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	3		30 Name and address of person wh	o completed cau	ise of death (Iter	n 23a) (Type,	Print)	0 2.1	11.	100	2/2	,2004
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	•	For State Registrer 1. Decedent's Name (First, Middle, Las		•	artment of Health and tificate of Death		Reg. No.	w 1-1/2 E	3. Time of Death
Physicia /Medic	al	MIRI	AM	н	MMELSTEIN 4b. City, Town, or Location of De	Januar	Day 20	Year 2004 unty of Death	9:11 p M
Examin	er	4a. Facility Name (If not institution, give	P		Baltimore Ci-	ty			N/A
Funeral Director		5. Social Security Number 6. Si 212-22-4323 1 Usual Residence of Decedent	ax 7. Age	(In yrs. last birthday) 79 Yrs.	If Under 1 Year If Under 24 H Months Days Hours M.		, 1924	9. Birthp Cour	place (State or Foreign htry) MD
Maryland -f show	tor	10a. State 10b. County MD N/A		10c. City, Town or Lo	cation			1	0d. Inside City Limits 1 Yes 2 No
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sicien: The law requires that the death certificate certificate been signed by the attending phys rector, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d.	Date of delive	ery Day Year
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the Hos ithin 24 hc the Fun impletely f	Medical	29a. Certifier (Check only one) 1	niner: On the basis of and manner sta	examination and/or in	vestigation, in my opinion, death or 29c. License number	ocurred at the time,	date and pla	ice, and due to	o the cause(s)
₩ ¥ 00		· m	MD	eath (Item 23s) (Tuno	19026		Janua		0 2004
15		30. Name and address of person who SINAI Ho 31. Date filed (Month, Day, Year) JAN 2 3 20	SPITAL .	- ROBERT	Holf mo				

		1 - For State Registrar			Depar		Health a Death		ental Hygi	ene 004	0172	8
Physicia	ın	1. Decedent's Name (First, Middle,	Last)			-			2. Date of Death Month	Day Year	3. Time of Dea	th
/Medica	al	Thomas M. H		1		h 0% T			January	4, 2004	6:42 AM	М
Examine	er	Joseph Riche	5 P. G. 1	,	4	b. City, Town, o	ltimor			4c. County of Dee	th	
uneral			. Sex 7. Ag	ge (In yrs. last bi		f Under 1 Year	If Under 2		B. Date of Birth (Month, Day,	9. Bir	thplace (State or For	reign
rector		091-24-5770 Usuel Residence of Decedent	1 ∑ M 2□F	80	Yrs.	Aonths Days	Hours	Min.	Apr 9, 1		Jersey	
fied at	tor	MD Baltin	ore	10c. City, Tow	vn <i>or</i> Locai Atons						10d. Inside City Lin 1 ☐ Yes 2X	
Exprint met be notified at	Director	10e. Street and Number 719 Maiden Choi	I DD	T 22		10f. Zip Code	000		10	g. Citizen of What Co	ountry?	
munt	Funeral	11. Marital Status	12. Was Decedent		13 Wa		228	nin2 (Spec	ify Yes or No.	USA 14. Race - Ame	orican Indian	
dical Exeminar	by Fun	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forces?	No		s Decedent of Hes, specify Cubi		, Puerto Ri	ican, etc.)	Black, Whit		
ical	ed	15. Decedent's	Education		. Deceden	t's Usual Occup	pation		16	6b. Kind of Business	Industry 111	ak
3	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO	d of work done NOT use retired		or working	,		ui	.IIC
event, the	ဝိ	1 Z 17. Father's Name (First, Middle, La	5			biolog		d- 81 /				
	Be	Thomas Smith	,						First, Middle, Ma lement	uden Sumame)		
i l	၉	19a. Informant's Name/Relationship	•	196	o. Mailing A	Address (Street				City or Town, State, a	Zio Code)	
'		Ruth Hopkins	/spouse							Catonsvil		.22
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☒ Donation 5 ☐ Other (Spe		20b. Place o cemete	of Disposition of Disposition of the Disposition of	on (Name of ory or other plac	ce)	Dai	te 20	c. Location - City or	Town, State	
ODCO.	Ì	21. Six abuse of Euneral RODA CL		ector	Sta Bal	ame and Addre te Anat timore,	ss of Facility Omy Bo	oard (21201	655 W. I	Baltimore	Street	
ing eu	edical Examiner	23a. Part1. Enter the disease, or of shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as	a consequence a consequence	of):	/	1		4.1	erse	Approximate Interval Between Onset and Death	
1 - 1 - 1 - 1	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		topic pregnancy her <i>(specify)</i>	,			23d. Date of del Month	ivery Day Year	
3	۵	Part II. Other significant conditions	contributing to death b	out not resulting in	n the unde	rlying cause give	en in Part I.		_	cco use contribute to		
	Completed								24a. Was an autopsy performe	g? prior to death?	topsy findings availa completion of cause	ble of
rector a	g Re	25. Was case referred to medical examiner?	Hospital:			Oth	or		Check only one)		11.05	
in le la ci	tion: 10	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Inju (Month, Da	ry 28b. 1	Time of njury	28c. Injun Worl	4 ∐ Nur:	280	5 Residence d. Describe how	ce 6 To her (Specinjury occurred	ity) HOSPIC	_
	Certification:	3 Suicide 6 Could not 4 Homicide determine	be one Blace of Inc	ury - At home, fa c. (Specify)	ırm, street,	-		-	Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,	
	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis of and manner sta	f examination an	e, death oc d/or invest	curred at the timi igation, in my of	ne, date and pinion, death	place, and occurred	d due to the caus at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)	
	ž	29b. Signature and title of certifier				29c. Licensi	e number		29d	Date signed (Month	Day, Year)	
		30. Name and address of person wh	hey MO	leath (Itom 03-1)	Tues D-	Da	278	60	JA	murry 5	1th, 2004	
		CHRISTOPHER I	KEARN	EYMO	(Type, Prin	zoi E.	Univ	Pku	y Br	Mt. Md	21218	
State gistra		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	1505	48			/			

DHMH 17 Rev 1/2001

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THOMS HORING

01 1 1 1 1	and / Department of Health and Mental Hygiene
State of Man	and / Denarment of Health and Mental Hydlene
Otate of Iviary	and / Bepartment of Health and Meritar Hygierie

Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** January 0312 M Jim H. Hawker 2004 /Medical 4b. City, Town, or Location of Death
Baltimore 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospita Dinai If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Sept 20, 1940 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Unk 6. Sex **Funeral** Days Months 1⊠M 2□F 228-19-8312 63 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or items 23a 5 Girard Drive 21244 USA Completed by Funeral unk 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No un 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married unk 1 ☐ Yes 2 📉 No Specify: white If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry unk then Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed withi Health and Mental Hygiene. unk unk unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unk Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Important: If item 27 Is any injury or other Sinai Hospital 2401 W. Belvedere AVenue Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State `4 □Donation 5 ♥Other (Specify) in state 21. Signa pro of Funeral Service Licensee State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Prostate Concer (end stage Priysician disease or condition resulting in death) /Medical Examiner Over whelming Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 Tyes 2 No. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 Unknown 1 ☐ Yes 2 ☐ No should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No this certificate has page 1 Yes director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 EP/Outpatient 3 DOA Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide To the Hospital filled 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 January 13, 2004 ddress of person who completed cause of death (Item 23a) (Type, Print)

E. Stone, M.D. 2401 West Belvelere Avenue 30. Name and 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 2 3 2004

Registrar DHMH 17 Rev 1/2001

Known as: Hawker, Jim

Maryland 21215-0036

Baltimore,

(Bell)

			1 - For State Registrar	State of Ma	ırylan	id / Depa <i>Cei</i>	artmen rtificate	t of H e of L	ealth a Death	and Me		iene	104	me a substantia	730
	Obveries		1. Decedent's Name (First, Middle, Last)							2. Date of Deat Month	h Day	Vana	3. Time o	of Death
	Physici /Media		George Franklin	Hoffman							Januar		Year 2004	2:15	5 A ^M
	Examir		4a. Fecility Name (If not institution, give				,		Location o	of Death	~		ty of Death		
			Quail Run Elder C					ry H				Balt	imore		
	Funeral		5. Social Security Number 6. Se	X DM 2□F 7.Age		last birthday)	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day, May 26,	Year)	Cou	olace (State	
1	Director		214-16-7934 X	X	83	Yrs.					May 26,	1920	Wes	t Vir	ginia
	and		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							IOd. Inside C	ity Limits
	Many f sh	ō	MD Baltimo	re		0v	erlea							1 🗌 Yes	21 No
	r 28a	rec	10e. Street and Number				10f. Zip	Code			10	Og. Citizen of	What Cou	ntry?	
	3a o	O I	5608 Daybreak Ter	race				21	206				ted S		
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Miculcal Estar illust must be notified at	Funeral Director	11. Marital Status	12. Was Decedent E	ver in U.	S. 13.	Was Deced	ent of His	spanic Orig	gin? (Spec	ofy Yes or No- lican, etc.)		ice - Americ		
ဖွ	after or fte	F	1 Never Married 2 Married	Armed Forces? 1XXYes 2 □ N If Yes, Give	o	1				, Puerto H	ican, etc.)		ack, White,		
8	iours iral',	d by	3XXVidowed 4 □ Divorced	Year or Dates:			1□Yes 2	X-XIVO	Specify:			Speci	ify: W	hite	
5	72 h	Completed	15. Decedent's Edu (Specify only highest grad	cation e co <i>mpleted)</i>		16a. Deced (Give	kind of wor	k done d	uring most	of working	g	16b. Kind of E	Business/In	dustry	
12	within ne. han	m	Elementary/Secondary (0-12)	College (1-4or 5-	+)		plosi	,		cian		Corr	ernme	n t	
2	iled v Hygie ther t		17. Father's Name (First, Middle, Last)			LA.	PIOSI				(First Adiable A			111	
and	ntal he d	Be	George F. Hoffman								(First, Middle, N Smith	alden Suma	me)		
Ξ	hould d Me mark matic	卢	19a. Informant's Name/Relationship (Ty			10h Mailin	a Address	/Street a			Route Number,	City or Town	C40.4- 7:-	C- 1-1	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinat must be notified at once.		John Hoffman (Son)	po, 1 1411)			4 Val					311 G			e CA
ē,	Hea Hea tem other		20a. Method of Disposition		20b. P							Oc. Location			_
OLL	ages anf of nt: If I		1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	Ga	lace of Dispo: emetery, cren rdens	natory or ot of Fa	he <i>r pl</i> ace ith) 1/2 Cemet	.4/U4		Baltim			
=	artmoortar		21. Signature of Funeral Service Licens		J Ga.				1				016,		
Ö	Depar Important in successions		Elenabeth &	e least	bi						al Home		VD 01	206	
4	¥ ×		23a. Part1. Emer the disease, or compl	ications that caused	the death	n. Do not ente	or the mode	of dying	, such as o	cardiac or	Baltir respiratory arre	nore, st,	MD ZI	Approximatinterval Bet	te
Š,	Physician		shock, of heart failure. List only or Immediate Cause (Final	Mekaskat		Contes	1. 10:	14 (in ku	10	, Prin	an		Onset and	Death
3	/Medical		disease or condition resulting in death)	Due to (or as a			0 000	, , , ,	001-10					cur-	LNOWN
	Examiner		Convention to the test and disease)											
100	D =	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequ	uence of):									
	acuter ind trans	Examiner	Cause (Disease or injury												
8760,	oe exe	Ě	resulting in death) cast	Due to (or as a	consequ	uence of):									
876	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		1								·			
9 X	ding p	Physician/Me	IF FEMALE:	3c. If yes, outcome of	d orogana										
Вох	that the death certified of by the attending detached for use as	ian	in the past 12 months?	1 ☐ Live birth 2	Fetal	death 3	Ectopic pre						ate of delive onth		Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	ime or de	aam ⊃∟	Other (spe	спу)							
۵.	that i	/ Ph	Part II. Other significant conditions con	tributing to death but	t not resu	Ilting in the un	derlying ca	use giver	n in Part I.		23e. Did toba	acco use con	tribute to th	e cause of o	leath?
OS	w requires that been signed I should be det	d by	Compression	hai V	ine	- Le	und,	ex	1111	clare	1 ☐ Yes		3 ☐ Prob		nknown
00	w req	Completed	Mult; inja	D.	PMAO	tia	C	11/	4		24a. Was an	245	Ware auto	nou findings	available.
Re	he law e has l	m	modely object	C V		4 1 04		- 0 /			autopsy		prior to cor death?	osy findings npletion of c	ause of
<u>ra</u>	ifficat or, pa	ပိ	25. Was case referred to medical						00 Bl	-4 D45 /			1 🗆 Yes	2 🗆 No	
Division of Vital Records,	Physician: The la r this certificate has	To B	examiner?	lospital:	t 2 🗆 I	ER/Outpatient	3□ 00/	Other			Check only one 5 ☐ Resider		(Co4	Amia	Ve di
Ö	g Phy er thi		27. Manner of Death	28a. Date of Injury (Month, Day		28b. Time of		c. Injury : Work?			d. Describe how			17113100	mil
0	ath. r: Aft	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day	rear)	Injury	М		? es 2 □ N	lo					,
N S	er der recto by th	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur	y - At ho	me, farm, stre	et, factory,	office		28	f. Location (Stre City or Town,		ber or Rura	Route Num	ber,
	rs after all Districtions and Districtio	Certification:		building, otc.	(<i>Openiy</i>	, 					City of Town,	State)			
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	edicai	29a. Certifier 1 Certifying Phys	sician: To the best of	my know	wledge, death	occurred a	t the time	, date and	place, an	d due to the cau	use(s) and ma	anner as st	ated.	,
	the F the F nplete	Medi	Unity .	and manner state	ed.	1011 211 201 1111)
	With To	~	29b. Signature and title of certifier	1.D.				License		770	4 29	d. Date signe)4
			100	L <i>V</i>				٠ (ل	-38	, , ,		11-2	- L		
-	51		TALITUTE OF 17	EEM.	700		ASTO	3RM	1 DX	ND -	M	D-2	122	.1	
	Sta Registra		JAN 23 200	32 Aegistrar	's Signat	ure L	and s								

		•	For State Registrar	State of Maryland		artment of F rtificate of		nd Mental H	ygiene Reg. No.	2004	01731
			1. Decedent's Name (First, Middle, Last)					2. Date of D	Death Day	Yeer	3. Time of Death
	Physici /Medio		Lucretia				itan	+ JANUA	4.	0, 2004	00:26 M
	Examin		4a. Facility Name (If not institution, give s	treet and number)	11	4b. City, Town, o	r Location of	Death	4c. 0	County of Death	h O
			ING Johns HOPK	in Hospiti	41	BAHIN	10RE	Um la a la ca		NI	H
	Funeral		5. Social Security Number 6. Sex 220-14-3831 □	7. Age (lin yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min (Month, I	Birth Day, Year) 30, 19	918 Mar	hplace (State or Foreign untry)
	Director	\	Usual Residence of Decedent	A 03				Oct.	30, 19	10 Hal	yrand
	yland now		10a. State 10b. County	10c. City,	Town or Lo	ocation					10d. Inside City Limits
	Mar.	io	Maryland N/A	В	altim	ore City					1√2 Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code	1007			en of What Co	untry?
	23a		1300 South Ellwood	Avenue			1224			J.S.A.	
	ar deg	nue	The state of the s	12. Was Decedent Ever in U.S. Armed Forces?	. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origir an, Mexican, I	n? (Specify Yes or I Puerto Rican, etc.)	No- 1	 Race - Ame Black, White 	
36	rs afte	γF	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		5	Specify: wh	ite
9	within 72 hours after death with the Maryland ene. then "neturel", or items 23s or 28e-f show ta Modical Examination mail be notified at	Completed by Funeral	15. Decedent's Educ	cation	16a. Dece	dent's Usual Occup	ation		16b. Kin	nd of Business/I	Industry
75	hin 7	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retired	during most o d)	of working			·
7	od wit	Con	4,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Homen	naker				n Home	
n	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last) William O'Neill					s Name <i>(First, Midd</i> etia Bond	lle, Maiden S	Sumame)	
<u>ya</u>	Men Merke Marke	٦ ا									
Maryland 21215-0036	12 st h and 7 is m traum		19a. Informant's Name/Relationship (Type Mary Hart- daughte:					or Rural Route Num treet Ral	-		1and 21224
<u>က်</u>	1 and Healt		20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Name of		Date		ation - City or	
non	ages ant of it: If it		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State Sacr	ed He	art of J	esus 1	/24/2004		-	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-1 show says injury or other traumatic svant, It a Medical Examinet must be notified at ance.		21. Sign ture of Funeral Service License	90	22	2. Name and Addre	ss of Facility	Charles	S. Zei	iler &	Son. Inc.
ä	Depa Impo sny it		+ Hessica 7	tose				nue Balti			-
	級		23a. Part . Enter the disease, or complice shock or heart failure. List only on	cations that caused the death.	Do not en	er the mode of dyin	ng, such as ca	rdiac or respiratory	arrest.		Approximate Interval Between
N.	Physician		Immediate Cause (Final disease or condition	sepsis							Two weeks
	/Medical Examiner		resulting in death)	Due to (or as a conseque	nce of):						
	Examine		Sequentially list conditions, b								
	led Isit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	rice oil:						
	al-tra	xar	that initiated events c. resulting in death) Last	Due to (or as a conseque	nce of):						
8760,	icate be executed physician and s the burial-transit	dicai l	d	l							
9	tificat ng phy as th	ledi									
Вох	eath certific attending p	an/N	230. was decedent pregnant	3c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d		Ectopic pregnancy	,		23	3d. Date of deli	*
	the at	Physician/Med	in the past 12 months? 1 □ Yes 2 ☎No 9 □ Unknown	4□Pregnant at time of dea 9□ Unknown		Other (specify)			-	Month	Day Year
P.0	that the di		Part II. Other significant conditions con	tributing to death but not result	ing in the u	nderhing cause an	on in Part I	23a Dic	tobacco us	e contribute to	the cause of death?
ds,	8 6 8	d by	at it.	inibating to doctor but not regalit	ing ar trio d	riddifyllig dddaa gif	on mir arti.		Yes 2		obably 4 Munknown
COL	w requir been si should	ete						24a. Wt	16.20	24h Were au	topsy findings available
Vital Record	The lav	Completed			· · · · · · · · · · · · · · · · · · ·			— aut	topsy rformed?	prior to c death?	completion of cause of
ta	ician: Th certificate rector, pag	Be Co	25. Was case referred to medical				26 Place o	1 Yes	2 🗷 No	1 Li Yes	2₩ No
>	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 █ No	ospital: 1⊠Inpatient 2□El	R/Outpatier	nt 3 DOA Oth		ing Home 5 ☐ Re		Other (Spec	cify)
n of	iding Physician: th. : After this certifica funeral director, p		27. Manner of Death 1 ■Natural 5 □ Pending	28a. Date of Injury 2 (Month, Day Year)	8b. Time o	f 28c. Injur Wor	y at	28d. Describe			
<u>S</u>	Attending r death. ector: After by the fune	catic	2 Accident investigation			M 1 🗆	Yes 2 □ No				
Division	l or Attendater deatl Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location City or T	(Street and own, State)	Number or Ru	ral Route Number,
	pitel ours a erel [29a. Certifier 1 Certifying Phys	sician: To the best of my knowl	ladge doat	h agguered at the tir	no date and	place, and due to th	10.001100(0)		atata d
	24 hc 24 hc Fun etely	edicai		ner: On the basis of examination and manner stated.	n and/or in	vestigation, in my o	pinion, death	occurred at the time	e, date and p	place, and due	to the cause(s)
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Me	29b. Signature and title of certifier	/		29c. Licens	e number		29d. Date	signed (Month	n, Day, Year)
			Wina most	MO		RE	5-00	90	Jani	uary i	20, 2004
	2		30. Name and address of person who con								
)			co North Welf	2 54	reet d	Baltimo	ore, Mari	gland	21287	<u></u>
45	Sta Registr		JAN 2 3 200	32. Registrar's Signatu	3	3462					

Isaiah J. Johnson
1- State

tate of Maryland / Department of Health and Mental Hygiene 2 🛭 🗎 🗓	0	17	13	
Cortificate of Dogth	Sport	1 1	174	-

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Division of Vital Records, P.O. Box 68760,

			Registrar		Cer	lilicate of t	Dealli		Reg. No.		
	Physici		Decedent's Name (First, Middle, Last,		Jol	nson		2. Date of De Month	Day	Year O.4	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death	Janua:	4c. County	of Death	658 a [™]
		Н	6511 Insey Stree			Forest	ville [If Under 24 Hrs.]				Georges
*	Funeral Director		5. Social Security Number 6. Se. 163-36-1358	x 7. Age (In yrs. Ia: MAM 2□ F 61	st birthday) . Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da	31,1942		ice (State or Foreign y)
-	r's		Usual Residence of Decedent			1		oury	2111342		
	Marylan f show	Į į	Maryland Prince	,	Town or Loc estvi					100	d. Inside City Limits 1 ☐ Yes 🏌 ☐ No
	r 28a	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Countr	y?
	23a o	aD	6511 Insey Str	reet		20747			USA	1	
	er dea tems	nuel	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No Rican, etc.)	14. Race Blac	- America k, White, et	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. See I show mental the marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinal must be notified at once.	b	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	☐ Yes 🟋 ☐ No	Specify:		Specify	B1a	ck
<u>.</u>	"natu	lete	15. Decedent's Edu (Specify only highest grad		(Give I	ent's Usual Occup kind of work done of OO NOT use retired	during most of worki	ng	16b. Kind of Bu	siness/Indu	istry
7	within lene. then	Completed	Elementary/Secondary (0-12) 1 1	College (1-4or 5+)	Labo		4)		Const	ruct	ion
	be filed wi tal Hygien d other th event, I've	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle	, Maiden Surnam	в)	
	ould by Menta varked vatic ev	ToE	Isaiah	Johnson			Dora	Anders	son		
ם ה	and is ma		19a. Informant's Name/Relationship (T)				and Number or Rura		-		
	of Health of Health of Health of Item 27 i		Corrine Mansfie			mboden intion (Name of		#101 Z	Alexand		Va . 22304
و	ages nt of h :: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	netery, crem	atory or other plac	(e)				
saltimore,	permit. Page Department of Importent: If any injury or once.		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 		22.	Valley	1 1/28				irginia
ñ	Department once		Robert BB	alur Ar.	26	05 S.SI	chin	n Fune on Rd	eral Se	rvic	e Va.22206
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	lications that caused the death.	Do not ente	r the mode of dyin	g, such as cardiac o	r respiratory a	rrest,		Approximate nterval Between
	Physician		Immediate Cause (Final disease or condition	Atheroscien	THE	Cardion	ascular	dista	re	(Onset and Death
¥/.	/Medical Examiner		resulting in death)	Due to (or as a conseque							
		Į.	Sequentially list conditions,	b. Due to or as a conseque	nce of:					-	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
Ď,	h certificate be executed ending physician and use as the burial-transit	I Exa	resulting in death) Last	Due to (or as a conseque	ince of):						,
68760	physicate physicate	dica		d					7		
X	nding use a	n/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnance	су				23d. Date	of delivery	,
	requires that the death certiticate be executed teen signed by the attending physician and hould be detached for use as the burial-transit	Physicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	leath 3∐ ith 5□	Ectopic pregnancy Other (specify)			Mon	th D	ay Year
T.	s that ned b e deta		Part II. Other significant conditions con		ing in the un	derlying cause giv	en in Part I.	23e. Did to	obacco use contri	bute to the	cause of death?
ğ	w require been sig should b	ed k	Chronic ale	enell m				1 🗆 🗅	Yes 2□No	3 🗌 Probab	oly 4 Dunknown
ပ္	has b	Completed by						24a. Was autop perfo	rmed? d	eath?	by findings available oletion of cause of
_	certificate rector, pag		25. Was case referred to medical				26. Place of Death			Yes 2	□ No
>	Physician: this certificatal director,	To Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ El	R/Outpatient	3□ DOA Oth	40		dence 6 X Othe	r (Specify)	at scene
on or	fing After fune	tlon: T	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation		8b. Time of Injury	28c. Injun World			now injury occurre		
ā	or Attend after death Director: / I in by the f	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office	2	28f. Location (S City or Tox	Street and Numbe vn, State)	r or Rural F	Route Number,
<i>i</i>	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical C		sician: To the best of my knowl iner: On the basis of examinatio and manner stated.							
	ro the within Fo the comple	Me	29b. Signature and title of certifier	. 17		29c. License	e number		29d. Date signed	(Month, Da	ay, Year)
	- 3 - 0		> Zalvalld	ACT		OCME			January	21 2	004
	X		30. Name and address of person who co	ompleted cause of death (Item 2	23a) (Type, F	Print)	on Charact	D-34.	man- 14	7	a 01001
	1,		EMBULLAH	44		TIT Per	nn Street,	ваттл	more, Ma	rytan	a 51501
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signatu		nehr					

Registrar

JAN 2 3 2004

State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Da **Physician** Barbara Jones 200 anvari /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BULLIMORO CITO spheral DHa NA Haryland 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sax Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days Min 1 M X F Yrs. 212-28-2344 Director 71 Va Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at M☐Yes 2☐No Md. Director NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1100 W. Pennsylvania Ave. Funerai 411 21217 Apt. USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. s 1 and 2 should be filed within 72 hours after if Heatih and Mental Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify Specify: Black Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assit. Hospital 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be I 0 Vernon Parham Lossi Lucas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11709 South River Patch Dr., Sheila Wooten Daughter-in-law Midlothian, Va. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete permit. Pages 1 Department of H Important: If ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) King Mem. Pk. 1-21-04 Randallstown, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility any ir Baltimore, Md. 21202 lien March F.H. East 1101 E. North Ave. 23a. P. rt1. Enter the disease, or complic tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): Physician thm disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed neumonio burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1 🗆 Yes 212 No or Attending Physicien: funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending within 24 hours after death. To the Funerel Director: Al 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WAZIR naryland Genera m 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

DHMH 17 Rev 1/2001

JAN 2 3 2004

	_ 1	State Registrar			ficate of D			. No.	w (; ') \
)husiai		Decedent's Name (First, Middle, Last)	,				Date of Death Month	Day Yeer	3. Time of Death
hysici: Medic/	al .	EMMA	Joyce				01 8	P002 05	9:55 a M
Examin		4a. Fecility Name (If not institution, give s		1	b. City, Town, or L			4c. County of Death	
		Future Care Canton		et hirthday)	Baltimo:	re If Under 24 Hrs.	8. Date of Birth	9 Birth	place (State or Foreig
uneral		5. Social Security Number 6. Sex	M 251F 84		Months Days	Hours Min.	(Month, Dav.)	(ear) Cou	place (State or Foreig Intry) and
rector	-	218-22-2364 Usual Residence of Decedent					08-05-	[414 122]	
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		10a. State 10b. County		, Town or Loca					10d. Inside City Limit
트립	١٥	Maryland N/A	A		Baltimor	e City			1X Yes 2 □ No
r 28a	Director	10e. Street and Number			10f. Zip Code		100	. Citizen of What Cou	intry?
23a o	a D	2613 Llewelyn Aven	ue		2	1213		U.S.A.	
E B	Completed by Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	5. 13. Wa	s Decedent of His	panic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
a d	Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give	10	Yes 2√x No	Specify:		Specify: wh:	ite
E G	d b	3 Midowed 4 Divorced	Year or Dates:	1			1 44	N 16 - 1 - 1 D 0	4.4
nett dise	ete	15. Decedent's Educ (Specify only highest grade		(Give ki	nt's Usual Occupat nd of work done du O NOT use retired)	ion iring most of worki		8b. Kind of Business/li	ndustry
han a	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		memaker			Own Home	۵
nt.	ပ္	8 17. Father's Name (First, Middle, Last)		110		18. Mother's Name	(First, Middle, Ma		
94 o	Be c		n Becker			Eı	mma Young	g	
mark	욘	19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Mailing	Address (Street ar	nd Number or Rura	i Route Number,	City or Town, State, Zi	ip Code)
27 is trau		Nan Joyce-Daughter	•	2613 I	lewelyn	Avenue B	altimore	, Maryland	21213
othe		20a. Method of Disposition	C4	ace of Disposi	tion (Name of story or other place		Date 20	c. Location - City or 7	own, State
y or		1 Burial 2 ☐ Cremation 3 ☐ R 1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	lawn Ce			/2004 Ba	altimore,M	aryland
ortar injur	1	21. Signature of Funeral Service License	90					el Funeral	
any ir		of willast	JXV					Maryland	21206
24		23a. Part . Enter the disease, or complishook, or heart failure. List only or	cations that caused the death	. Do not enter	the mode of dying,	, such as cardiac	or respiratory arres	it,	Approximate Interval Between
sician		Immediate Cause (Final	Approtei	()	eo ocorie				2 weeks
edical		disease or condition resulting in death)	Due t (or as a consequ		CO V 00 1-C				2 00 4
miner		Sequentially list conditions							
_	ner	Sequentially list conditions, if any, leading to immediate the line Index in Cause (Disease or injury	Due to (or as a consequ	ience of):					
nd transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	3.						
ian a urial-		resulting in death) tast	Due to (or as a consequ	Jence of):					
physician and s the burial-transit	dical		d						
attending p	a a	IF FEMALE:	23c. If yes, outcome of pregna	nev				22d Date of deli	
or us	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal	death 3 □8	ctopic pregnancy Other (specify)			23d. Date of deli- Month	Day Year
the a	ysic	1 ☐ Yes 2≱⑤ No 9 ☐ Unknown	4□Pregnant at time of di 9□Unknown	aun 5L	Other (specify)				
ed by the detached		Part II. Other significant conditions con	ntributing to death but not resi	ulting in the und	ferlying cause give	n in Part I.	23e. Did toba	cco use contribute to	the cause of death?
29 g	d by	Hypertensière Art	evi lo eclestiel	Corone	Vrewber	Decale	_ 1 ☐ Yes	2 □ No 3 □ Pro	bably 4 Nunknov
peen si should	ete	Polomay Eulo	13.		-		24a. Was an	24h Were au	topsy findings availat
has Je 2	Completed	4 01100			. 4		autopsy	ed? prior to death?	completion of cause o
certificate ha		(o ica condition	isease D	secrue	Coc	00 Division (Division		-	2□ No
	Be	25. Was case referred to medical examiner?	Hospital:	FD/0	3□ DOA Othe	r	h (Check only one) ice 6 □Other (Spec	26.1
this aldi	- To	1 ☐ Yes 2 No 27. Manner of Death	1 Inpatient 2 I	ER/Outpatient 28b. Time of	28c. Injury	at	28d. Describe hov		ary)
	to	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work M 1 □ Y	? ′es 2 □ No			
ter ner	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho		et, factory, office			eet and Number or Ru	ral Route Number,
or: After the funer		4 Homicide	building, etc. (Specify	/)			City or Town,	State)	
Director: After in by the funer	erti		the state of southern	wledge, death	occurred at the tim-	e, date and place,	and due to the car	use(s) and manner as	stated.
Director: After in by the funer	al Certification:	29a. Certifier 1 Certifying Phy	sician: To the best of my kno	tion and/ac.	antination in mir an		rou at tiro tirrio. Ga	to allu piaco, allu duo	to the cause(s)
Director: After in by the funer	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	iner: On the basis of examina and manner stated.	tion and/or invi					to the cause(s)
Director: After in by the funer		(Check only 2 Medical Examione) 29b. Signature and title of certifier	iner: On the basis of examina and manner stated.	tion and/or invi	29c. License	number	29	d. Date signed (Montl	n, Day, Year)
Director: After in by the funer	edical	(Check only 2 Medical Examione) 29b. Signature and title of certifier	iner: On the basis of examina	tion and/or invi		number	29		n, Day, Year)
or: After the funer	edical	(Check only 2 Medical Examione) 29b. Signature and title of certifier	iner: On the basis of examina and manner stated.	tion and/or invention and/or invention	29c. License	number 667	29	d. Date signed (Montl	n, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Eula 3: 38p M 0. Kina 19 Jan 2004 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Towson

If Under 24 Hrs. Stella Maris Hospice Baltimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Year) 5. Social Security Number Days 1 ☐ M 2 🖾 F 63 Yrs Sept.11,1940 Virginia 214-38-2093 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 1 No Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1104 Roseanda Court 21220 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2/2 Married 1 ☐ Yes 2X No Specify: SpecifyWhite 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Meals on Wheels Elementary/Secondary (0-12) College (1-4or 5+) Clerical 12th 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle, Maiden Sumame) Guyle Patrick Anna Belle White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1104 Roseanda Court Baltimore MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/22/04 Baltimore MD OakLawnCemetery * 4 ☐ Donation 5 ☐ Other (Specify)

19a. Informant's Name/Relationship (Type, Print) Wayne J. King 20a. Method of Disposition

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

Be

Examiner

Physician/Medical

Completed by

Be

Certification; To

Medical

Funeral

Director

in than "natural", or iteme 23a or 28a-f ehow the Medical Examiner rount be nutified at

permit. Peges 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na eny injury or other traumatic event, the Madic once.

Physician /Medical Examiner

burial-transit

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signed by the aid be detached for

been si should

certificate has

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After

funeral director,

filled in by

completely

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attending physicien and

The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

Hospital or Attending Physician:

death.

within 24 hours after deatl To the Funeral Director:

EULA KING

the Maryland

with

death

72 hours after

Maryland 21215-0036

Baltimore,

p.m.

2004

JANUARY 19,

21. Signature of Funeral Service Licensee 23a Part1. Enter the disease, or complications that ceused the death. Door shock, or heart failure. List only-end cause on each line.

22. Name and Address of Facility Connelly Funeral Homeof Essex300 MAce Ave. Baltimore MD 21221 Approximate Interval Between Onset and Death

tenter the mode of dying, such as cardiac or respiratory arrest,

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

_ a	LUNG CANCER	
	Due to (or as a consequence of):	
b	Due to (or as a consequence of):	

Due to (or as a consequence of)

IF FEMALE 23b. Was decedent pregnant

in the past 12 months? ☐Yes 2 XNo 9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Tetal death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d Date of delivery Month Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Y Unknown

24a. Was an autopsy performe 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

25. Was case referred to medical examiner? 1 Yes 2 XNo 27. Manner of Death 1 X Natural

5 Pending investigation 6 ☐ Could not be 28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2300 DULANEY VALLEY RD.

28c. Injury at Work? M

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

TIMONIUM, MD 21093

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 Homicide

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

29c. License number D43725 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year)

32 Registrar's Signature

State Registrar

JAN 2 3 2004

		·	For State Registrar	State of Maryla	ind / Dep		lealth and I	Mental Hyg	ienez (104	0 1 7 3 7
	Physicia /Medic Examin	al	Nancy Elizabeth Hancy In the state of the state	Kohlhepp	10.1-	4b. City, Town, o	r Location of Death		Day 19 4c. Cour	2004 nty of Deeth	10:20 PM
i	Funeral Director		219-80-2551	Bayriew Medic DX 26 F 7. Age (In y) 36	cal (enter s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.			Coun	lece (State or Foreign http: 7 land
	ne Maryland 8a-f show	Director	Usual Residence of Decedent 10a. State Maryland 10b. County n/a		City, Town or L altimor	e			0-03:		0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	3a or 2	i Dire	10e. Street and Number 4205 Heckel Avenu	e		10f. Zip Code	21206		_	States	_
136	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural" or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates:	U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🗓 No	dispanic Origin? (S an, Mexican, Puert Specity:	pecify Yes or No- o Rican, etc.)	В	lace - Americ lack, White, city: Whi	etc.
Maryland 21215-0036	within 72 hou ene. than "natura ne Medical E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	edent's Usual Occup be kind of work done DO NOT use retired sic Psych	during most of wor d)	rking		Business/Inc	-
/land 2	should be filed and Mental Hygi marked other umatic event, t	To Be Co	17. Father's Name (First, Middle, Last) John D. Kohlhepp		'	-	18. Mother's Nar	me (First, Middle, i M. Ostene	Maiden Sum lorf	ame)	
	T la		19a. Informant's Name/Relationship (1 John D. Kohlhepp	Type, Print) Father	8010 Balt	ing Address <i>(Street</i> Remington imore, Ma	and Number or Ru Avenue ryland 2	iral Route Numbei 1244	, City or Tow	m, State, Zip	Code)
Baltimore,	of He		20a. Method of Disposition 1 ፟ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		Place of Disposements, cre Cathedr	osition (Name of matory or other place al Cemete	erv Jan.	23, 200	20c. Location 4 Balt	n-City or To :imore.	wn, Stete
Balt	permit. Page Department Important: It sny injury o		21. Signature of Funeral Service Lice	soo Elwar Moo 3	33 87	2. Name and Addre	ty Rd. Ra	andallsto	wn, M	D21133	-4784
2.3	Physician /Medical Examiner		23a. Party/Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a	rania requence of):		orhage		est,		Approximate Interval Between Onset and Death Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Cons
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rds, P.	w requires that been signed by should be deta	ed by Ph	Part II. Dther significant conditions of		•	underlying cause giv	ven in Part I.			ontribute to th	ne cause of death?
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	ysician: The lis certificate his director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	ent 3 DOA Oth	ner	ath (Check only or fome 5 Reside		Other (Specify	y)
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not betermined	28e. Place of Injury - A	t home, farm, s	M 1	ry at rk?]Yes 2 □ No	28d. Describe he	reet and Nui		I Route Number,
á	ospital or hours after uneral Dire		29a. Certifier US Certifying Ph	building, etc. (Spenysicien: To the best of my niner: On the basis of exam	knowledge, dea	th occurred at the til	me, date and place	e, and due to the c	ause(s) and	manner as st	lated.
	To the H within 24 To the F complete	Medical	29b. Signature and title of certifie	and manner stated.)	29c. Licens	se number	2	9d. Date sig	ned (Month,	Dey, Year)
	\bigvee_{φ}		30. Name and address of person who	completed cause of death (I	tem 23a) (Type EaSte	Re O. Print) Ern Ave	nue, Ba	altimore	2, M	13 2	1224
	Sta		31. Date filed (Month, Day, Year)	32. egistrar's Si		melle					

			1 - For State Registrar	State of Marylan		artment of rtificate of		ind Me	ental Hy	rgiene		01738
	Physici	2D	1. Decedent's Name (First, Middle, Las					2	2. Date of De	eath Day	Year	3. Time of Death
	/Medi		EDDIE HUBER						JANUA	Ry 17	2004	0912 M
	Examir	er	4a. Facility Name (If not institution, give			4b. City, Town,		f Death		4c. Co	ounty of Death	
ķ.			UNIVERSITY of M 5. Social Security Number 6. S		lant hirthday)	BALTIM If Under 1 Year		A Hrs 6	B. Date of Bi	dh	N/A	ala a Chan a Famin
	Funeral Director			XM 2□ F 7. Age (III y/s.)	Yrs.	Months Days		Min.	B. Date of Bir (Month, Da 6/30/]	ay, Year) 1 Q 2 7	NC Sirth	place (State or Foreign ntry)
			Usual Residence of Decedent	70				1	0/30/	1.721	NC	
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation						10d. Inside City Limits
	Mar Mar	향	DC	WA	SHING	CON						1 ☐ Yes XX No
	or 28)Le	10e. Street and Number			10f. Zip Code				10g. Citize	n of What Cou	ntry?
	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28a-f ehow he Mudical Exciniter: Just be notified at	by Funeral Director	1615 NORTH PORTA	L DRIVE NW			0012				S.A.	
	er deg	nue	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. \	Was Decedent of If Yes, specify Cul	Hispanic Orig ban, Mexican,	in? (Spec , Puerto Ri	fy Yes or No can, etc.)	o- 14.	Race - Ameri Black, White,	
36	s afte	Ę.	1 ☐ Never Married 2 🛣 X arried 3 ☐ Widowed 4 ☐ Divorced	XXYes 2 □ No If Yes, Give		1 □ Yes XX No	Specify:			Sį	pecify: B	LACK
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ή.	in 72	Completed	(Specify only highest gra	de completed)	(Give	kind of work done DO NOT use retire	e during most	of working	7	100. Killa	Of Business/ii	loustry
7	with iene.	Шо	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		ESTATE I				REA	L ESTA	ГЕ
Ö	Hygid Other	BeC	17. Father's Name (First, Middle, Last)				18. Mother	r's Name (First, Middle	, Maiden Su	ımame)	
<u>a</u>	Ald be Alenta rked tic e	To B	SAMUEL SELMON KI	ING			MAI	RY DA	VIS			
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f ehow or other traumatic event, the Mudical Examiner with burnoulfied at		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Stree	t and Number	r or Rural	Route Numb	er, City or T	own, State, Zij	Code)
	and 2 ealth m 27 I		EMMA L. KING		1615	NORTH PO	ORTAL I	DR NW	, WASI	HINGTO	N D.C.	20012
ore	of He fiten r oth		20a. Method of Disposition 1 X Yurial 2 Cremation 3 C		lace of Dispo emetery, crer	sition (Name of natory or other pla	ace)	Da	te	20c. Loca	tion - City or T	own, State
Ĕ	Pages ment of ant: If it ury or o		'4 □Donation 5 □Other (Specify	CE	DAR H	ILL CEME	TERY 1,	<mark>/23/</mark> 2	004	WASHI	NGTON,	NC
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licht	500	22	. Name and Addr	ess of Facility	FIN	K FUNI	ERAL H	OME, P	A
	70 E 9 9		KELLY GREGORY	FINK #M01148		26 CRAIN					MD 210	061
68760,	Physician and physician and physician and physician and physician and the purial-transit	al Examiner	23a. Part Enter the disease, on comshock or heart failure. Est only Immediate Sause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. RESPIRAT. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of): IC SH Lence of):	page 100 miles	\wedge	ION ANTROV	Jack	M ELMMER		Interval Between Onset and Death
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	that ned b	by Pt	Part II. Dther significant conditions of	ontributing to death but not resu	ulting in the un	ndertying cause g	ven in Part I.		23e. Did t	obacco use	contribute to t	he cause of death?
g	quires n sign								10	Yes 2.[X]N	No 3 ☐ Prot	oably 4 Unknown
၀	s been si s been si 2 should	Completed							24a. Was		24b. Were auto	ppsy findings available
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ā	an: tufica tor, p	Be C	25. Was case referred to medical				26. Place	of Death (1 □ Yes Check only o		1 ☐ Yes	2 NO
\leq	ysici is cer direc	To B	examiner? 1X Yes 2 ☐ No	Hospital: 1 Mnpatient 2 🗆	ER/Outpatien	it 3 DOA	thac				Other (Special	(v)
Division of Vital Records,	ig Ph ter th neral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		ury at	28	d. Describe	how injury o	ccurred	
Ö	andir. ath. or: Af	atlc	1 □Natural 5 □ Pending 2 ☐ Accident investigation	01-13-2004	10:41]Yes 2 X ∫N	lo Si	ıbject	drive	er struc	k guardrail.
Š	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury · At ho building, etc. (Specify	me, farm, str	eet, factory, office)	28	f. Location (Street and A	lumber or Rura	al Route Number, P1ke and
	ital o	Cer			HOOOWAY	<i>!</i>						ring, MD
2	To the Mospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 X Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of my know niner: On the basis of examinat and manner stated.	wledge, death tion and/or inv	n occurred at the t vestigation, in my	ime, date and opinion, death	place, an h occurred	d due to the at the time,	cause(s) an date and pla	d manner as s ace, and due to	stated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licen	se number			29d. Date s	igned (Month,	Day, Year)
	111		1/1			Dax	0597	139		JALIA	17 Val	2004
	AHI		30. Name and address of person who	completed cause of death (Item	23а) (Туре,	Print)						, 2004
_	1		HUNISH GOYAL	MD 29 S. C	OREFUE	ST. I	BALTI	MOR	E. M	D:	21201	
	Sta	**	31. Date filed (Month, Day, Year)	32. Registrar's Signal					1			

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature JAN 2 3 2004

			For State Registrar	State of Mar		epartment of H Dertificate of I		Mental Hygiei Reg.	time for the wife	01739
	Physici		1. Decedent's Name (First, Middle, Last Rosemane	es les		-			Day Year 21 200 4	3. Time of Death
No.	/Medic Examin		4a. Fecility Name (If not institution, give	_ /			Location of Death	/	4c. County of Deet	1
ì	Funeral Director		5. Social Security Number 6. Se 212-50-6003		In yrs. last birtho	Months Days	MORE Hours Min.		n/a 9. Birt Co 938 Ge	hplace (State or Foreign untry) rmany
	and w		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town o	or Location				10d. Inside City Limits
	Maryl a-f sho	tor	Md. n/	a	Balt:	imore				1 ☐XYes 2 ☐ No
	th with the 23s or 28s	al Director	10e. Street and Number 201 Warren Ave.	Apt. 1	04	10f. Zip Code 2123	80	10g.	Citizen of What Co	untry?
036	inf. Pages 1 and 2 should be filed within 72 hours after death with the Maryland criment of Health and Mental Hyglene. Critant: if item 27 is marked other than "natural", or items 23a or 28a-f show njury or other traumatic event, it a Medical Examination in collied at a njury or other traumatic event, it a Medical Examination in a collied at a	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【☆Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give △ Year or Dates:	er in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐XNo	ispanic Origin? (S) in, Mexican, Puert Specity:	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, White Specify: W	
Maryland 21215-0036	within 72 ho lene. than "natur the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(C)	ecedent's Usual Occup Give kind of work done fe. DO NOT use retired Ctory Worke	during most of wor f)	king	. Kind of Business/	•
land 2	should be filed nd Mental Hygi i marked other umatic event, I	o Be	17. Father's Name (First, Middle, Last) Michael	Α.	Barth			ne (First, Middle, Maid ina	den Sumame) Bri	tz
	and 2 shou ealth and N n 27 is mai		19a. Informant's Name/Relationship (T) Cathy D. Rozanko		t.) 19b. M	tailing Address <i>(Street a</i> 30 S. Charl	and Number or Ru .es Stree	ral Route Number, Ci t, Baltimo	ore, Md.	Zip Code) 21230
Baltimore,	Pages 1 and nent of He sut: If item		20a. Method of Disposition 1 Burial 2 Toremation 3 4 Donation 5 Other (Specify)		cemetery,	isposition (Name of crematory or other place) W. Crematory			altimore	
Balt	permit. Pages Department of Important: If it any njury or once.		21. Signature of Funeral Service Licens	Commi	M	McCully- 130 E. F	ss of Facility Polyniak Fort Ave.	Funeral H Baltimore	Home p.A.	230
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compositions, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	ne cause on each line. a	CAPACAL consequence of	I enter the mode of dying Dr. farchon				Approximate Interval Between Onset and Death SO MINU KS
,0	tificate be executed ig physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co		Failure				10 des
68760,	ificate b g physic as the b	edical	•	d. Ceronay	arten	alscase				10 years
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	quires that in signed by uld be deta	þ	Part II. Other significant conditions co	ntributing to death but	not resulting in th	ne underlying cause give	en in Part I.	23e. Did tobacc		the cause of death?
Division of Vital Records,	The law requir	Completed	L					24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	1.	other all pos Other	ne.	th (Check only one)		
ion of	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	atlon; To	1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 28a. Date of Injury (Month, Day Y	28b. Tim	ne of 28c. Injun	4 Inursing in	ome 5 Residence 28d. Describe how in		cify)
Divis	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.		, street, factory, office		28f. Location (Street City or Town, St		ral Route Number,
,	24 hours 25 hours Funer etely fills	Medical	29a. Certifier (Check only one) 1X Certifying Phy Medical Exam	rsician: To the best of einer: On the basis of einer and manner state	xamination and/o	death occurred at the tin or investigation, in my o	ne, date and place pinion, death occu	and due to the cause rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and little of certillier	1 /		29c. License			Date signed (Month	
•	$\vec{\lambda}_{c}$		30. Na. e and address of person who c	Mynych	MO	DOC.	24022	Ja	nuay 21,	2004
	1/		Jobut My	grych 1	nD	101 Sout	Theor	er Staff	66 1hone	2004 re, MO 21225
	Sta Regista		31. Date filed (Month, Day, Year)	32. Registrar's	Sognature	South !				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 () ()

		State Registrar Amend Itel				.5 0, Dou		Date of Deatl	ng. No.		3. Time of Death
cia	n Ì	1. Decedent's Name (First, Middle, L	II KE	n Kelle	∍ y			Month	Day	Yeer	11:30AM
Ca	1	- CLI ZHBCT		LL 1	4h Cib	. Town, or Location		IAN		y of Death	11.50.
ine		la. Fecitity Name (If not institution, g					IMOR	C) A	
ļ			ARYLAND MO	(In yrs. last b				Date of Birth (Month, Day,			place (State or Foreign
i r	1	214-01-6131	1□ M 25⊈F	88	Yrs. Months	Days Hour	rs Min.	,000 (Month, Day) 3/02/19	Year) 15		ntry) MD
	1	Usual Residence of Decedent		. 00	1.		, , , , ,	3/02/12			
		10a. State 10b. County		10c. City, To	wn or Location						10d. Inside City Limits
	jo	MD Baltim	nore		Catons	ille					1 ☐ Yes 2 🛣 No
	Director	10e. Street and Number			10f. Z	p Code		10	0g. Citizen of	What Cou	ntry?
		2106 Edmondson A	ve.			21228			USA		
	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ever in U.S.	13. Was Dec	edent of Hispanic ecity Cuban, Mex	Origin? (Specifican, Puerto Ric	y Yes or No- an, etc.)		ce - Ameri ck, White,	
1	7	1 Never Married 2 Married	If Yes, Give	lo	1 ☐ Yes	2⊠ No Spec	city:		Specia	fy:	
	p p	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:	1.0	a. Decedent's Us	ual Occupation			16b. Kind of E	Rusinass/In	<u>White</u>
	Completed	15. Decedent's (Specify only highest of	grade completed)		(Give kind of v	ork done during n	nost of working		TOD. KING OF E	303111933/11	dustry
	E .	Elementary/Secondary (0-12)	Cottege (1-4or 5	+)		memaker			Own	ı Home	2
		17. Father's Name (First, Middle, La	ist)	1	110		other's Name (F	irst, Middle, N			
	To Be	Benjamin Landrum	1				Marv	Larner			
	ř	19a. Informant's Name/Relationship		15	b. Mailing Addre	ss (Street and Nu				, State, Zip	Code)
		Sharon Landrum/N	liece	2	106 Edmo	ndson Av	ve. Bal	ltimore	MD 2	1228	
	1	20a. Method of Disposition		20b. Place	of Disposition (N	ame of	Date		20c. Location		own, State
١		1 ⊠ Burial 2 □ Cremation 3 *4 □ Donation 5 □ Other (Spe				Cemetery	01/20/	/2004	Baltin	ore.	MD
ouce	1	21. Signature of Funeral Service Lic	200			and Address of Fa					
		12/10/10/1	(turk)		736 Ed	lmondson	Ave. Ba	altimor	e, MD		
		23a. Part1. Enter the disease, or co	omplications that caused	the death. D	not enter the m	ode of dying, such	as cardiac or re	espiratory arre	est,		Approximate Interval Between
ı		tmmediate Cause (Final disease or condition		MON	A						Onset and Death
		resulting in death)	Due to (or as								G 00 C2 . 5
		Sequentially list conditions,	b. PRIO		EPTIC	EMIA					manths
	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequenc	,	0 -			-		5
	Examiner	that initiated events resulting in death) Last	c. INFE	RIOR		CAVA	THRO	MBU	>		amonths
	<u> </u>	Toodking in county case.	Due to (or as	a consequenc	o 01).						
	edlcai		d								
		tF FEMALE:	23c. If yes, outcome	of pregnancy					23d D	ate of deliv	rerv
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	ysic	1 ☐ Yes 2 12 No 9 ☐ Unknown	9□ Unknown								
		Part II. Other significant condition	s contributing to death b	ut not resulting	in the underlying	cause given in P	art I.	23e. Did to	pacco use cor	ntribute to	the cause of death?
	d by							1 □ Y€	s 25 No	3 ☐ Pro	bably 4 Unknown
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i	Ę.							autops	ned? 2 0X No	death?	mpletion of cause of
						26. P	Place of Death (6		/	10,103	20,10
	a	25. Was case referred to medical		- 0000	Outpatient 3	Other	Nursing Home	20 100		ther (Speci	fy)
	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent ZLIERV		28c. Injury at	286	d. Describe ho	ow injury occu	irred	
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	To Be	examiner? 1 ☐ Yes 25 No	28a. Date of Inju (Month, Da	7	. Time of Intury M	28c. Injury at Work? 1 ☐ Yes	2 □No				
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	Certification: To Be	examiner? 1 Yes 25 No 27 Manner of Death 1 Naturat 5 Pending investiga 2 Accident 6 Could no determin 29a Certifier 18 Certifying	28a. Date of Injunction of the led 28e. Place of Injunction be led 28e. Place of Injunction, et	y Year) 28k ury · At home, c. (Specify) of my knowled	farm, street, fact	1 ☐ Yes and at the time, dat	28 and place, and	City or Town	n, State) ause(s) and n	nanner as	stated.
	Certification: To Be	examiner? 1 Yes 25 No 27. Manner of Death 1 Naturat 5 Pending investiga 3 Suicide 4 Homicide 6 Could no determin 29a. Certifier (Check only one) 1 Medical E:	28a Date of Inju (Month, Da tton of be led 28e. Place of Injuding, et	y Year) 28t ury - At home, c. (Specify) of my knowled f examination	farm, street, fact	1 ☐ Yes and at the time, dat on, in my opinion,	e and place, and death occurred	d due to the call at the time, d	ause(s) and mate and place	nanner as	stated. to the cause(s)
	To Be	examiner? 1 Yes 25 No 27. Manner of Death 1 Naturat 5 Pending investiga 3 Suicide 4 Homicide 6 Could no determin 29a. Certifier 6 Cartifying (Check only 2 Medical E.	28a. Date of Injunction atton 28e. Place of Injunction 28e. Place of In	y Year) 28t ury - At home, c. (Specify) of my knowled f examination	farm, street, fact	1 ☐ Yes only, office	e and place, and death occurred	d due to the call at the time, d	ause(s) and mate and place	nanner as and due in a	stated. to the cause(s)
	Certification: To Be	examiner? 1 Yes 25 No 27. Manner of Death 1 Naturat 5 Pending investiga 3 Suicide 4 Homicide 6 Could no determin 29a. Certifier (Check only one) 1 Medical E:	28a. Date of Inju (Month, Da 28e. Place of Inju building, et	y Year) 28t ury - At home, c. (Specify) of my knowled f examination	farm, street, fact	1 ☐ Yes and at the time, dat on, in my opinion,	e and place, and death occurred	d due to the call at the time, d	ause(s) and mate and place	nanner as and due in a	stated. to the cause(s)
	Certification: To Be	examiner? 1 Yes 25 No 27. Manner of Death 1 Naturat 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person w	28a. Date of Injunction at the led 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction, et 28e. Place of Injunction, et 28e. Place of Injunction, et 28e. Place of Injunction, et 28e. Place of Injunction, et 28e. Place of Injunction, et 28e. Place of Injunction, etc.	ry y Year) 28t y Y	farm, street, facting, death occurrand/or investigating) (Type, Print)	1 Yes	e and place, and death occurred	d due to the c.	ause(s) and mate and place	nanner as and due led (Month)	stated. to the cause(s)

Registrar

JAN 2 3 2004

			for State Registrar	State of	Marylan	d / Depa <i>Cei</i>	artment rtificate	of H	ealth a Death	and M	ental Hyg	ienez ()	04	01742
	-1.		1. Decedent's Name (First, Middle	e, Last)							2. Date of Deat Month		Year	3. Time of Death
	Physici: /Medic		Gordon R.	Kanzler							January			3:00 PM M
	Examin		4a. Facility Name (If not institution						Location of			4c. County	of Death	
		K.	Joseph Rich			la se bisebula ()	If Under 1		imore If Under:		9 Date of Birth		9 Rinth	place (State or Foreign
	Funeral		5. Social Security Number 214–36–3061	6. Sex 1 M 2 ☐ F	7. Age <i>(In yrs. I</i> 64	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, Apr 21,	Year) 1939	Cou	ntry)
127	Director		Usual Residence of Decedent		04		11				ирт 21,	1000		. y zarra
	yland 10W		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	a-f si	ctor	MD			Ва	Ltimor	e						1X Yes 2 No
	or 28	ire	10e. Street and Number				10f. Zip (Code			1	0g. Citizen of \	What Cou	ntry?
	23a	la	524 N. Charles					212				US		can Indian.
	ar dec	Funeral Director	11. Marital Status	Amped For	dent Ever in U. ces?	S. 13.	Was Decede If Yes, speci	ent of Hi ify Cuba	spanic Ori n, Mexican	gin? (Spe i, Puerto l	city Yes or No- Rican, etc.)		ck, White,	
36	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes Giv	Θ		1 ☐ Yes 2	No	Specify:			Specif	v: v	vhite
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f show ta Meulical Exaction most be notified at	led	15. Deceden	t's Education		16a. Dece	dent's Usua	Occupa	ation	t at warti		16b. Kind of B	usiness/lr	ndustry
215	nin 7.	ple	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1	-4or 5+)	life.	kind of worl DO NOT us	e retired	iuning mos)	(OF WORKI	ig			
	od wit	Completed	12	0			bart	ende					erage	2
pu	d oth	Be	17. Father's Name (First, Middle,								(First, Middle, I		ne)	
yla	Men Men Marke	2	Louis Kanzl			40- 14-18		/Ct			e Colbe		State 7	in Codo)
Maryland	12 should be filed within h and Mental Hygiene. 7 Is marked other then "traumatic event, Ita Me.		19a. Informant's Name/Relations Jackie Parrish								<i>l Route Number</i> Len Burn		210	
	1 and Health em 27 ther to	1	20a. Method of Disposition	1, 515001	20b. P	lace of Dispo	osition (Nam	ne of	1			20c. Location		
סַר	Pages nent of I int: If its		1 Burial 2 Cremation		State	emetery, cre	matory or ot	ther plac	θ)					
Baltimore,			*4 Donation 5 Other (S 21. Signature -un ral Service Ona Ld			2	2. Name and	d Addres	s of Facili	ty	655 W.	D - 1 + 4		Charach
Ba	permit. Departr Imports any inji		onald	2 / /CO	irector		altimo		•			baltim	ore	Street
	Fnysician /Medical Examiner	Jer	23a. Part 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Due to (ach line.	uence of):					CNON			Approximate Interval Between Onset and Death
8760,	cate be executed oblysicien and the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conseq	uence of):								
.O. Box 68	that the death certificate ted by the attending physidetached for use as the t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live b	come of pregna inth 2 Feta ant at time of d	Il death 3	⊒Ectopic pro ⊒ Other (spe						ite of deliventh	very Day Year
Δ.	es that the igned by th be detache	by P	Part II. Other significant conditi	ions contributing to de	eath but not res	ulting in the o	anderlying ca	ause giv	en in Part I	l.	23e. Did to	bacco use con	tribute to	the cause of death?
ğ	w requires been sign should be										1 XIY	es 2 🗆 No	3 Pro	bably 4 Unknown
Vital Records,	The law ate has b page 2 sl	Completed							***		24a. Was a autop: perfor	med?	Were aut prior to c death? 1 \(\text{Yes}	topsy findings available completion of cause of
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medica examiner?					Oth	00		(Check only or			11 5"
on of \	ling Phys	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendi	28a. Date		28b. Time of Injury		28c. Injur Wor	4 🗆 NI		me 5 Resid			ity) NesPica
Division of	af or Attending s after death. I Director: After d in by the fune	Certification;	3 Suicide 6 Could	not be 28e. Place	of Injury - At hing, etc. (Special	ome, farm, s fy)	treet, factory	y, office			28f. Location (S City or Tow	treet and Num n, State)	ber or Ru	ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in E	edical	29a. Certifier (Check only one) . Certifyi	ing Physician: To the I Examiner: On the b and man	best of my kno asis of examina ner stated.	owledge, dea ation and/or i	nvestigation	, in my o	pinion, dea	nd place, ath occurr	ed at the time, o	date and place,	and due	to the cause(s)
	To t To t Com	Σ	29b. Signature and title of certific	er (\sim			e number	, 10,		29d. Date signe		
			Much	XXM	n ar	N		74			<u> </u>			
			30. Name and address of person	n who completed caus	se of death (Iter	~	, Print)	30	1 6	V	Parol	BIL	/	17212c
			31. Date filed (Month Day Year	r) 32 B	egistrar's Sign	ature 1	Mark V	. , , ,		,	N CC	10116	- 44	
	St Regist	ate trar	31. Date filed (Month, Day, Year	3 2004	More	A R	hade	j						

LANUARY 17/2004 3 pm

GORDON KANZLER

			For State Registrar	State of Maryla			of Health a of Death			ene 200	01743
			1. Decedent's Name (First, Middle, Las						2. Date of Death Month	Day Ye	3. Time of Death
	Physicia /Medic		Hazel	Kraft					January		
X.	Examin		4a. Facility Name (If not institution, give			4b. City, T	own, or Location of	ol Death		4c. County of D	
			Manor lare Ko	ssville			ossville			Baltin	nore
	Funeral Director		21101010	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Months	Days Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,)	Year)	Birthplace (State or Foreign Country) laryland
	and		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	cation					10d. Inside City Limits
	Aaryl:	ō	MD N/A		Baltim	070 Cd					1 TYYes 2 □ No
	28a-	Director	10e. Street and Number		Dartimo	10f. Zip (100	g. Citizen of What	Country?
	with	ă	608 Dale Avenue			101. 2.0	21206				ŕ
	death with the Maryland ims 23a or 28a-f ehow rinual be rivdiffed at	Funeral	11. Marital Status	12. Was Decedent Ever in I	U.S. 13.	Was Decede		igin? (Spe	cify Yes or No-	United 14. Race - A	States Imerican Indian,
0	riter	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No			ent ol Hispanic Ori fy Cuban, Mexicar —		Rican, etc.)	Black, V	Vhite, etc.
3	ors a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2	X No Specify:			Specify:	White
215-0036	be filed within 72 hours after death with the Marylan deathly giene. de Hygiene. de ther then "natural; or items 23s or 28s-f show event, the Medical Executant result by the lifest at	Completed	15. Decedent's Ed (Specify only highest grad		16a. Dece	dent's Usual	Occupation done during mos	t of working	16	6b. Kind of Busine	ess/industry
Z	thin 6.	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	e retired)	(O WOINII	·9		
7	e filed within al Hygiene. I other then ' vent, the Ma	Con	7		Dea	autici				Hair	
	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name	(First, Middle, Ma	aiden Sumame)	
<u>x</u>		2	Jesse Curtis Bu	11					cl Caltr		
Maryland	A 10 - M		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailie	ng Address	(Street and Numbe	er or Rural	Route Number, (City or Town, Stat	e, Zip Code)
	es 1 and 2 of Health I itam 27 I		Kathleen Sweeney	(Daughter)	608	Dale	Avenue	Balti	more. Ma	aryland	21206
9	of H if ital		20a. Method of Disposition 1 ☐ Burial 2 1 To Cremation 3 ☐	Removal from State	Place of Dispo cemetery, crer	natory or oth	e of her place) 1/	26/02		Dc. Location - City	
E	Pag ment ant: jury		1 ☐ Burial 2 ☑ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify				hington				Maryland
gaitimore,	permit. Pages 1 Department of H Important: If its any injury or of		21. Signature of Funeral Service Licens	//	22 M	Name and	Address of Facility -Dippel	y Funer	al Home.	Inc	
ш	E S E O B	1 1	23a. Part1. Enter the disease, or comp	Selenski	- 6	415 B	elair Ro	ad	Baltimor	re. Marv	land 21206
			Shock, or pear railure. List only t	ATO CAUSO OF OACH INTO.	ath. Do not ent	er the mode	of dying, such as	cardiac or	respiratory arres	st.	Approximate Interval Between Onset and Death
المر	Physician /Medical		Immediate Cause (Finat disease or condition resulting in death)	a	1 c El Hwa	المان	भेप				
	Examiner		1	Due to (or as a conse							DAY!
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	CIRL T	140.00	Ç				
	ted nsit		cause. Enter Underlying Cause (Disease or injury	200 10 (01 20 20 100	440.100 017.						
_ Ps	ate be executed hysician and the burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):						
09/	siciar buri	cai									1
200	certificate nding phys			d							
ROX	leath certifical attending phy I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr		_				23d. Date of	delivery
ň	death e atten ed for u	ciai	in the past 12 months?	1□Live birth 2□Fet 4□Pregnant at time of]Ectopic pre] Other <i>(spe</i>				Month	Day Year
o.	the c y the achec	Jysi	9 Unknown	9□ Unknown							
S,	w requires that the de been signed by the s should be detached	by PI	Part II. Other significant conditions co		sulting in the u	nderlying ca	use given in Part I.		23e. Did toba	cco use contribut	e to the cause of death?
Sp	quire; n sig ald be		REMAR FAIL	IRE					1 ☐ Yes	2 □No" 3 □	Probably 4 □Unknown
ecord	law rec as bee 2 shou	iete							24a. Was an	24b. Were	autopsy findings available
Ĕ	o = 0	Completed							autopsy performe	prior death	to completion of cause of 1?
VItal	ician; Th certificate ector, pag	Ö	25. Was case referred to medical				26 Place	of Dooth	1 ☐ Yes 2 ☐ (Check only one)		/es 2□No
		0 8	examiner?	Hospital: 1 ☐ Inpatient 2 [TER/Outpatier	t 3□ DO4				ce 6 □Other (S	Inacihi)
0		L.	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		c. Injury at Work?		8d. Describe how		респу)
0	Attanding F r death. ector; After by the funer	atio	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day 19ar)	Injury	М	1 Yes 2 l	No			
DIVISION	if or Attancater death Director;	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place of Injury - At I	home, farm, str	eet, factory,	office	2			Rural Route Number,
5	al or s afte ni Dir	Sert	4 Tromodo	building, etc. (Spec	ny)				City or Town,	State)	
	To the Hospital within 24 hours a To the Funeral Completely filled	edicai (29a. Certifier 1 Gertifying Phyone Check only 2 Medical Exam	rsician: To the best of my kn iner: On the basis of examin and manner stated.	nowledge, death nation and/or in	occurred a vestigation,	t the time, date an in my opinion, dea	d place, a th occurre	nd due to the cau d at the time, date	se(s) and manner e and place, and	as stated. due to the cause(s)
	ro th rothin compl	Me	29b. Signature and title of certifier			29c.	License number		290	d. Date signed (Me	onth, Day, Year)
	> - 0		Doru M	ກ		3	05/2 1		77.	an sall	2000
•	/	1	30. Name and address of person who d	ompleted cause of death (Ite	m 23a) (Tyne	Print)	3306			للار ١٠٠	July 1
	5		30. Name and address of person who of DEWNIS H. ODGE	10 1232 R	Des Ko	Dur	£ 202	Ross	VILLE KOH	F COR B	AUD, MD 21237
	Sta	te	31. Date liled (Month, Day, Year)	32. Flegistrar's Sign	nature	9		4	112		
	Registr		IAN 2 3 28	MA A Same	IF B	sul!					

			1 - For State Registrar	State of	Marylan		artment of rtificate o				Reg.	Even Sul	04	01744
L	Physici	an	Decedent's Name (First, Middle, Last, Daisy I.						_	2. Date of Month		Day	Year (1	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give				4b. City, Town	, or Location	of Death		war	4c. County	2007	5/1000
			Saint Agnes Hospi				Balti			,				
	Funeral Director		5. Social Security Number 213–18–3356 6. Sec	7.	Age (In yrs.	last birthday) 34 Yrs.	If Under 1 Yea Months Day		Min.	8. Date of (Month) Jan.	Birth Dey, Ye 8, 1	ar) 920	Coun	lace (State or Foreign try) 1and
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits
	Maryl s-f sho	tor	Maryland		E	Baltimo	re							1X Yes 2 No
	or 282	Olrec	10e. Street and Number	_			10f. Zip Code				10g.	Citizen of	What Coun	itry?
	s 23a	erai [1331 Georgetown Ro	oad 12. Was Decede	ant Ever in 11	c 12	21 Was Decedent o	230	Vicinia / Ca	nodu Vos o			d Sta	
36	ırs after de il', or Item zamınısı	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Force 1 Tes 2 If Yes, Give Year or Date	es? ⊠No		was Decedent of f Yes, specify Cu 1 ☐ Yes 212 N	ıban, Mexic	an, Puerto	Rican, etc.)		ck, White,	
21215-0036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or Items 23e or 28e-f show marked other than "natural".	Completed	15. Decedent's Edu (Specify only highest grad		or 5+)	(Give	dent's Usual Occ kind of work don DO NOT use reti	e during mo	ost of work	ring	16b		susiness/Inc	dustry
	filed withi Hygiene. other than	Cor	17. Father's Name (First, Middle, Last)	unk.		Ho	memaker	18. Mot	her's Nam	e (First, Mic	idle. Maid	Own]		
Maryland	Mental Mental arked o	To Be									,		-, CII	
ary	2 should and Men is marke		19a. Informant's Name/Relationship (Ty			19b. Mailir	ng Address (Stre	et and Num	ber or Rui	al Route Nu	mber, Cit	ty or Town,	, State, Zip	Code)
	1 and Health am 27 Iher tr		Edgar Fogler, Sr.		20b. P		Georgeto	own Ro	400	Baltir Date			vland City or To	21230
JOE L	Pages nent of H int: If Ite		1 ☑ Surial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)		ate C	emetery, crei	matory or other p			4/04				
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic as <u>once.</u>		21. Signature of Funeral Service Licens	00	mea	Ga ²²	Name and Add	ress of Fac	ility 1 Fun	eral H	Home	A+ Mr	MP .	aryland Inc.
	40244		23a. Part1. Enter the disease, or compl	ications that cau	sed the death	12	50 Wash	ıngtor	ı Blv	d. E	lkric	lge, 1	Maryla	and 21075 Approximate
B	Physician		shock, or heart failure. List only or trmediate Cause (Final disease or condition	ne cause on eac	in line	lo								Onset and Death
	/Medical		resulting in death)	Due to (or	as a conseq	uence ot):	1							day)
	Examiner	10	Sequentially list conditions,	o. Due in (or	as a consequence		mel							days
	uted 3 ansit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Ch	1	1 (A) P	Viller	Trees	la	ord s	lis-	de		Ye was
o,	an and	Exa	resulting in death) Last				J		N.F. S	(
8760,	cate be executed physician and the burial-transit	dlcal			eme	nlid								years
Box 6	death certifi e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 montie?		h 2 ☐ Fetai	death 3	Ectopic pregnar						ite of delive	ry Dav Year
o.	0 0 0	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnar 9□Unknow	nt at time of di m	eath 5	Other (specify)							ouy Foul
ري م	res that the de signed by the s be detached t	by Ph	Part II. Other significant conditions con	ntributing to deal	th but not resi	ulting in the u	nderlying cause (given in Par	t I.	23e. D	id tobacc	o use cont	tribute to th	e cause of death?
ords	w require been sig should b									1	Yes	2 🗆 No	3 Proba	ably 4 Abnknown
Records,	sician: The law requires that the certificate has been signed by thirector, page 2 should be detache	Completed								p	atobsy erform <u>e</u> d	? !	prior to con death?	osy findings available inpletion of cause of
Vital		Be C	25. Was case referred to medical examiner?		/				ce of Deat	1 □ Ye		NO	10 163	208140
	Physic this ce al dire	ု	1 ☐ Yes 2/ ☐ No 27. Manner of Death	lospital: 1 np		ER/Outpatier	IL 3LI DOA			ome 5 R)
O	iding Phi th. : After thi funeral	tion	1 □Natural 5 □ Pending 2 □ Accident investigation	(Month,	Day Yeer)	28b. Time of Injury	W	ork? ∐Yes 2[28d. Descri	De now in	ijury occuri	190	
Division of	writel or Attending Physician: rours after death. neral Director: After this certific filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined	28e. Place of building	Injury - At ho , etc. (Specify	ome, farm, str y)	eet, factory, offic	9			n (Street Town, St		er or Rural	Route Number,
9		Medical Co	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exami	ner: On the basi	is of examina	wledge, death	n occurred at the vestigation, in my	time, date a	and place, eath occur	and due to t	the cause	e(s) and ma and place,	anner as sta	ated. the cause(s)
	Fo the H with n 24 Fo the Fu completed	Med	29b. Signature and title of certifier	and manne	r stated.		29c. Lice	nse numbei			29d. [Date signe	d (Month, L	Day, Year)
	SW .		> Syousy N	IIP.	2		Do	0605	0		Jan	nuar	422	,2004
13	3		Q, Name and address of person who co	om leted cause	of death (Item	23a) (Type,	Print)	Bal	time	ire,	M	0	121	.g
	Sta		31. Date filed (Month, Day, Year)		istrar's Signa	ture		40						1
	Regist	ar	JAN 2	3 200₽	1000	100	Ances	8 8						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ [] [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician 1920 January 20 2004 Charles Leizear /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Neme (If not institution, give street and number) Examiner of Baltimore. Baltimore City Sinai Hospital 7. Age (In yrs. last birthday) If Under 1 Year Months Deys If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Year) Birthplace (Stete or Foreign Country) 5. Social Security Number **Funeral** 1☑M 2□F 81 Dec 15 1922 Director 214-12-0640 Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a Stete 10b County Item 27 is merked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner natation incitional 1 ☑ Yes 2 ☐ No Director Мд Carroll Sykesville 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street end Number 7200 Third Avenue C-111 21784 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritei Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) National Data Corp. Elementary/Secondary (0-12) College (1-4or 5+) executive vice president 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fether's Name (First, Middle, Last) 2 should be f and Mental F Charles Robert Leizear Nellie Byer 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other trau Mrs. Jean S. Leizear (spouse) 7200 Third Ave., C-111, Sykesville, Md. 21784 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date 1 ☐ Burial 2 🎧 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 1-23-04 Sykesville, Md 22. Name end Address of Fecility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Page Haight Herbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Heart Failure Immediate Cause (Finel diseese or condition resulting in death) /Medical Examiner 34 days Examiner signed by the ettending physician and d be deteched for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Acrtic value endo carditis

Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Mitral value endocarditio 23b. Did tobacco use contribute to the cause of deeth? Part II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown \$ 24b. Were autopsy findings aveileble prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No After this certificate funeral director, pag 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manuer of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 24 hours

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Alejan Aro Segueira 2401 west Belvedere Avenue Baltimore Marrland 21-215
31. Date filed (Month, Day, Year) 2 3 2004

equerra M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D0024726

29d. Date signed (Month, Day, Yeer)

lanuary-20-2004

Registrar

Medical

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year)

To the Hosp within 24 hor To the Fune completely fi

State of Maryland / Department of Health and Mental Hygiene 🕦 🕦 į, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Yee **Physician** JANUARY 14, 2004 6:00 PM **JOHN** LUYK /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GLEN BURNIE 239 WOODHILL DR., APARTMENT B ANNE ARUNDEL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/28/1942 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** XXM 2 F 381-42-2439 MICHIGAN Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f shov the Medical Experience ust be natified at 1 ☐ Yes XX No MD) ANNE ARUNDEL GLEN BURNIE Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 239 WOODHILL DRIVE, APARTMENT B 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XX es 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: WHITE þ 3 Widowed 4 Vorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 DEPARTMENT OF DEFENCE **Budget Analyst** permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked ofth any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) JOHN JAMES LUYK ALTHEA (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KIMBERLY SHEEHAN - DAUGHTER 832 WINDSOR ROAD, ARNOLD, MARYLAND 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 XX emation 3 Removal from State BAXVIEW CREMATORY 1/23/2004 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service Licensee

KELLY GRAGORY FINK FINK FUNERAL HOME, PA 22. Name and Address of Facility #M01148 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 23a. Part | Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OBOHAR? **Physician** /Medical Due to (or as a consequence of) Examiner IAMSETES WE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine and Due to (or as a consequence of): physician a the burial-1 Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? res 22No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred I or Attanding P after death. | Director: After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MUNICL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1406 S. CRAIN HIGHWAY GLENBURHIE MD 2661 NOM 32. Registrar's Signature State September of Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registra Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician Month M 2004 January /Medical 4b. City/Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner 10 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 💢 F Months -34-9106 Mar Director Usual Residence of Decedent 10a. State 10b. County Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Maryland | 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: ģ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) fited within Hygiene. Ker 2 omema 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ages 1 and 2 should be fit of Health and Mental His. If item 27 is marked other Be Se Vina ant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ma, 21144 vern Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) injury or permit. Page Department of Important: M GreenMount Cremater 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Iny Seph ral Hom North Ave. 216 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immed to Cause (Final disease or condition resulting in death) Physician cel mo /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit certificate be executed Due to (or as a consequence of). Box 68760, Physician/Medical as the attending IF FEMALE use a 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy ξ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 Yes 2 🗆 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform page 2 No Division of Vital 1 ☐ Yes 2 2 1 🗌 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 🗌 Yes 4 Nursing Home 2 1 Inpatient 2 ER/Outpatient 3 DOA esidence 6 Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Natural 2 Accident 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? or Attending 5 Pending Injun death. 1 ☐ Yes 2 ☐ No investigation the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) I in by t 4 - Homicide Hospital completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the

State Registrar

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29b. Signature

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tiller cirole 31. Date filed (Month, Day, Year) JAN 2 3 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29c. License numbe

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** JANUARY 10, 2004 10:50 A M ELIZABETH HANCE LOEFFLER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE JOHNS HOPKINS HOSPITAL tf Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min 8. Date of Birth Month, Day, Year) MARCH 20, 1980 6. Sex Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthdey) 5. Social Security Number **Funeral** Days 1 □ M 2 X X NEW JERSEY 23 227-33-9532 Director Usual Residence of Decedent permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, Its Madical Experiments. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1XYes 2 □ No MD WASHINGTON SHARPSBURG Directo 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21782 USA 223 E. MAIN STREET Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) FINANCIAL Elementary/Secondary (0-12) Coltege (1-4or 5+) RECEPTIONIST 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be SUSAN PEPPER JOHN V. LOEFFLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 223 E. MAIN STREET, SHARPSBURG, MD 21782 JOHN V. LOEFFLER/FATHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State JANUARY JANUARY 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) SHEPHERDSTOWN, WV ELMWOOD CEMETERY 14, 2004 22. Name and Address of Facility BROWN FUNERAL HOME, P.O. 21. Signature of Funeral Service Licensee leo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CYSTIC FIBROSIS EXACERBATION (LUNG) **Physician** MONTH /Medical Due to (or as a consequence of): Examiner 23 YEARS FIBROSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown DIABETES should t 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No this certificate 1 🗌 Yes 2 No 26. Place of Death Check on one director, Be 25. Was case referred to medical examiner' Other: Certification; To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation completely filled in by the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after To the Hospital within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 2004 6 MD D46141

DHMH 17 Rev 1/2001

Registrar

Michael

31. Date tiled (Month, Day, Year)

Registra Signature

1830 E. Monument Street, 5th floor

MD

Beltman

21205

30. Name and address of perion who completed cause of death (Item 23a) (Type, Print)

Boyle

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The law requires that the		Phy	9 Unknown			_								
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		O .		т							perform 1 Tes 2		n? Yes 2	□ No
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		-	27. Manner of Death	28a. Date of In	tient 2 ER/C	Outpatient Time of					e 5 Residen		Specify)	
or Attending	; After e funer	at or	1 Natural 5 Pending 2 Accident investigation	(Month, E	Day Year)	Injury	М	c. Injury Work?	es 2 🗆 N	i	2000.00 1,01	inquity cocumou		
	Director; in by the	l Lici	3 Suicide 6 Could not be							28f. Location (Street and Number or Rural Route Number			Route Number,	
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Hospitel or 24 hours after		dical	29a. Certifier (Creat only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										ed. he cause(s)	
To th	To th	<u> </u>	29b. Signature and title of certifier				29c.	License	number		290	d. Date signed (M	lonth, Da	ay, Year)
1			h. Queter Darle, M.D. D23809 1/22/04											
		1	30. Name and address of person who	1	death (Item 23a)) (Type, f						1/22/	U-4	
1			L. Austra Doyle, ,		eneloum	-	cer c	h-,	22 3	S. G	reane St.			0 21201
	Stat		31. Date filed (Month, Day, Year)		trar's Signature									
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ORIGINAL

				State of Maryland / Depart State Registrar Certification Registrar			ne2004	01750			
_		Physic /Medi		1. Decedent's Name (First, Middle, Last) Cherry Miller		2. Date of Death Month Jan 22	Day 2004 Year	3. Time of Death 1:50a ^M			
		Exami	ner		b. City, Town, or Location of Death		4c. County of Deat				
				Upper Chesapeake Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Bel Air		Harford				
		Funeral Director			Months Days Hours Min.	8. Date of Birth (Month, Day, Ye May 7 19	(ar) 9. Birti	nplace (State or Foreign untry)			
				Usual Residence of Decedent		May 7 19	Vi	cginia			
		within 72 hours after death with the Maryland ene. than "netural", or Items 23a or 28a-f show than "netural" Examinating the motified at	Director	10a. State 10b. County 10c. City, Town or Locat MD Harford	Joppa			10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
		ith th	Dire		10f. Zip Code	10g.	Citizen of What Co	untry?			
		ath w	ra	351 Ellsworth Place	JSA						
		ter de Item	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2⊠ Married 1 □ Yes 2√2√No	s Decedent of Hispanic Origin? (Sp es, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	ican Indian, , etc.			
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	and	a d la la la la la la la la la la la la la	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maid	len Surname)				
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		Physician	0. 1	23a. Pan1. Enter the disease, or conclications that caused the death. Do not enter the shock, or heart failure. List entry one cause on each line. Immediate Cause (Final disease or condition	he mode of dying, such as cardiac o	or respiratory arrest,	ore MD	Approximate Interval Between Onset and Death			
	1	/Medical Examiner		resulting in death) Due to (or as a consequence of):	I Endocar			and any			
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5	Rec.	has ge 2 :	d m			24a. Was an autopsy performed?	autopsy prior to completion of caus				
herry	a	ician: Th certificate ector, pag		25. Was case referred to medical		1 ☐ Yes 2 💢 N		2 🕅 No			
P	Ξ	ding Physician: The la h. After this certificate has funeral director, page 2	To Be	examiner?	26. Place of Death						
0	ō	g Phys er this eral di		27. Manner of Death 28a. Date of Injury 28b. Time of		me 5 Residence 28d. Describe how in					
_	io	ttanding I death. ctor: After y the funer	atto	1 Accident investigation (Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No						
Miller	Division	al or Atta s after de l Diracto d in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
X	A	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occ 2 Medicel Examiner: On the basis of examination and/or investigand manner stated.	curred at the time, date and place, a gation, in my opinion, death occurre	and due to the cause(ed at the time, date a	s) and manner as s nd place, and due to	ated. the cause(s)			
	0>	To the To the Comp	Σ	29b. Signature and title of certifier	29c. License number	29d. D	Day, Year)				
		n	ļ	Julian mo	NO036719	>	1/22/2				
		3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print),	211	in and	1			
		Sta	te	Sherit H. Osman, M. D. 520 Upper C 31. Date filed (Month, Day, Year) . Registrar's Signature	Poo36719	ve, Bell	lic, MD.	21014			
		Registra	ar	JAN 2 3 2004)						

		For State Registrar	State of Mary		epartmei Certifica					iene g. No.	004	0175	. 161 toxade
		Decedent's Name (First, Middle, Last)							2. Date of Deat Month	h 3. Tir Day Yeer		3. Time of Death	1
Physicia /Medic			Jasper	Mat	nley				1	7	2004	2328	М
Examin		4a. Fecility Name (If not institution, give	street and number)				Location of	of Death			4c. County of Deeth		
		Sinai Hospital		fant biet		salto. or 1 Year	If Under	24 Hrs	8. Date of Birth	N,		lace (State or Fore	ian
Funeral Director		5. Social Security Number 6. S 240–38–4479	X	yrs. last birth 74 Y	Months		Hours	Min.	(Month, Day,		Coun	N.C.	igii
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nylank how		10a. State 10b. County		c. City, Town	or Location						1	0d. Inside City Lim 1 X Yes 2 ☐ I	
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fler d	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces?	Armed Forces?		37			Rican, etc.)		Black, White, etc.		
ours a	by	3√ Widowed 4 □ Divorced	1 □ Yes 2√ No If Yes, Give X Year or Dates:	Year or Dates:			Specify:			Spe	Specify: Black		
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Mithin 19	ш	Elementary/Secondary (0-12)	Elementary/Secondary (0-12) College (1-4or 5+) Masonry						Brick C1			aning	
be filed within 72 hours after death with the Maryland ale Hygiene. de thygiene debt results or tems 23a or 28a-f show event. The Madical Examiner was the notified at		17. Father's Name (First, Middle, Last)		Jnk			18. Mothe	er's Name	(First, Middle, I	Maiden Sur	name)		
id be ental ked o	To Be	Roosevelt Manl	ev				Rea	ather	Lynch				
should and Men amarke	-	19a. Informant's Name/Relationship (19b.	Mailing Addres	s (Street	and Numbe	er or Rura	I Route Number	City or To	wn, State, Zip	Code)	
and 2 and 2 ealth a n 27 is		Geraldine Stato			402 St					Md 21			
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Entrice Pages transit of I tent: If it it it it it it it it it it it it it		* 4 ☐Donation 5 ☐ Other (Specif	y)	Mt Zic	n Ceme		(3-2004		down,	Md	_
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y the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown			,, _							
requires that the	by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give: in Part 23e. Did lobace							oacco use	cco use contribute to the cause of death?			
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law rec	Completed								24a. Was a autops	n 2	4b. Were auto	psy findings availa mpletion of cause	ble of
The The ate h	E O								perfor	ned? 2. XNo	death?		
OT VICAL MEC Physician: The lav this certificate has ral director, page 2.	Be	25. Was case referred to medical examiner?				0.1		of Death	(Check only on	e)			
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Jing After fune	lon	27. Manner of Death 1 Natural 5 ☐ Pending 2 Accident investigation		28e. Place of Injury - At home, farm, street, factory, office						28d. Describe how injury occurred			
VISION r Attending er death. rector: Alter by the fune	fical	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Injury					28f. Location (Street and Number or Rural Route Number,					
bpitel or A ours after terel Dire	Certification:	4 Homicide	building, etc. (Specify) City or Town, Sta							n, State)	tate)		
사 유 교 등 의 유 교 등	edical C	(Check only 2 Medical Exa	nysician: To the best of miner: On the basis of ex	amination and	death occurre	d at the tir	me, date ar opinion, dea	nd place, ath occurr	and due to the cred at the time, d	ause(s) and ate and pla	d manner as s	tated. o the cause(s)	
To the Hos within 24 h To the Fur completely	Med	one) 29b. Signature and title of certifier	and manner state	1.	2	9c. Licens	se number		2	9d. Date si	gned (Month,	Day, Year)	
£ ₹ 5 8)	Duddy	1 M.	0	046	306	5		1/1	4/06	r r	
7	1	30. Name and address of person who	completed cause of dear	h (Item 23a) (Type, Print)	AN	URA	DHI	1 REON	24 04	5	/	-
		821 Neutau	v Stree	f Su	Ete#	3/2	2, B	al	timo	te 1	402	120/	
Sta	ate	31. Date liled (Month, Day, Year)	32. Registra	Signature	S. A.	asto s	,						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 19 Ruby J. McCall 2004 2245 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** J.H.H. Bayview Hospital Baltimore Md. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days 1□ M 2□ F Months Hours 210-34-1609 Director 10-20-42 Md Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-1 show notified at Md. Baltimore Y Yes 2 No Director NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 COURT Per 5520 Frankford Ave. 238 21206 death Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian. the Medical Examinar Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Š 1 ☐ Yes 2√2 No Specify: Specify: Black 3 Widowed 4 Divorced Vear or Dates "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinnent of Health and Mental Hygiene.
ant: If item 27 is marked other than 12th grade Dept. Of Human Resources n Resources State of Md

18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Booker Faulcon Jerldene Wilkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Niccole McCall Daughter 5520 Frankford Ave., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 0 = 0 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cem. 1-23-04 Baltimore, Md permit. Departn 21. Signature of Funeral Service Licenses 22. Name and Address of Facility any ir Baltimore, Md. 21202 her March F.H. East 1101 E. North Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition atheroscleratio Pnysician /Medical resulting in death) Due to (or as a consequence of) **Examiner** DDM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): P.O. Box 68760, physician by Physician/Medical as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No
9 Unknown Month Year 4☐ Pregnant at time of death 5 Other (specify) the should be detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 3 No 3 ☐ Probably 4 ☐ Unknown Completed Ronal Frailure 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2. No 2 XER/Outpatient 3 DOA this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No after death. investigation in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide within 24 hours a To the Funeral I (*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) tha 29c. License number 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) 2 D28987 r 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. SIGOI LOCH RAVEN BLYD SPORL BALTO. MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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	Physici		1. Decedent's Name (First, Middle, Last)	ERRITT		2. Date of Death	3. Time of Death 3 200 M
	/Medio Examir		4a. Facility Name (It not institution, give	street and number)	4b. City, Town, or Location of Death BUTIMORE	4	4c. County of Death
	Funeral Director		5. Social Security Number 6. Sec. 215 - 22 - 46 40	7. Age (In yrs. last birthday	2/10/11/10	8. Date of Birth (Month, Day, Yea	9. Birthplece (State or Foreign Country)
	<u>.</u>		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	Location	· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits
	the Mar 28a-f st	rector	MD · U/A	BAITIN	MORE 10f. Zip Code	10g. (1 Yes 2 □ No
	eath with s 23a or must be	Funeral Director	3411 DiLlon	57 a	2/224		U. 5. A
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show ship injury or other traumatic event, the Medical Enamemer must be notified at ance.	by Fun	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Pres 2 □ No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 No Specify: 	Rican, etc.)	Black, White, etc.
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_	and 2 she salth and n 27 is m		19a. Informant ame/Relationship (Ty	pe, <i>Print</i>) 19b. Mai 55NEA 340	iling Address (Street and Number or Rura	E BAIT	or Town, State, Zip Code) HD. 21234
Baltimore,	Pages 1		20a. Method of Disposition 1 Burial 2 Cremation 3 R 1 Donation 5 Other (Specify)	20b. Place of Disp cametery, cre	position (Name of emajory or other place) HILL CEM, 200	21	Location - City or Town, State
Balti	permit. Departm Imports any inju		21. Signature of Fineral Service picenso	Skarde h.	22. Name and Address of Facility In FFMAU 12-SKA	RDA BA	8 HUDSON 7 HITO NID 21724
37	79		23a. Part1. Enter the disease or complishock, or heart failure. List only or Immediate Cause (Final	cations that caused the death. Do not ende cause on each line.	()		Approximate Interval Between Onset and Death
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n of	ng Phys fter this neral di	on; To	1 ☐ Yes 2 55No 27. Manner of Death ↑SAutural 5 ☐ Pending	ospital: 1 Inpatient 2 ER/Outpatie 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at 2	ne 5 AResidence 28d. Describe how inj	6 □Other (Specify) ury occurred
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	To the Hospital within 24 hours a To the Funaral L completely filled	Medical Co	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	lician: To the best of my knowledge, dea ner: On the basis of examination and/or in	ath occurred at the time, date and place, a investigation, in my opinion, death occurre	nd due to the cause(ed at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifies	and mahner stated.	29c. License number	29d. D	ale signed (Modth, Day, Year)
7) \ \	(30. Name and address of person who co	mpleted cause of death (Item 23a) (Type	9 0 3 8 0 3 3 Print) 1 / 20 1 / Av	z Am	T 1221
4	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	JIJNUUM JIV	- (5/00	1.07/1/1007
	Registr	ar	JAN 2 3 2004	The second			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) James P./ Matthews 2. Date of Death 3. Time of Death Day **Physician** AM /Medical Neme (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day) 7. Age (In yrs. last birthday) Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 10 M 2□ F Min. Months Days Hours 21807-82 Usual Residence of Deceden Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County is marked other than "natural", or Itams 23a or 28a-f show sumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S.
Amed Forces?
1 Ryes 2 No
Hyes, Give
Year or Dates: Funeral 5 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Yes 2□ No Baltimore, Maryland 21215-0036 Specify 3 Widowed 4 □ Divorced Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry entary/Secondary (0-12) College (1-4or 5+) th GRADE Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Be Mental mue ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rutal Route Number, City or Town, State, Zip Code) Son) If item 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place 5 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. cenmount * 4 □ Donation 5 Other (Specify) Vaughne 21. Signature of Funeral Service Licensee 22. Name and Address of Facility reene Funeral Service 515 Balto. Nati 23a. Pert1. Enter the disease, or complications that caused the death. shock, or hear failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attanding Phyaician: The law requires that the death certificate be executed burial-frau Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be 22 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No 2 1 Yes 2 ER/Outpatient 1 Inpatient 3□ DOA After this the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No To the Funeral Diractor: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours after Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title

State Registrar 30. Name and address of person who completed cause of d

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ORIGINAL

(Item 23a) (Type, Print)

32. Registrar's Sign

McNEAL BROCKINGTON III MD

6609 REISTERSTOWN RD. #104

BALTIMORE, MD. 21215

			1 - For State Registrar	State of Maryla	and / Depa			Mental Hyg	_	01755
Н			1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea	ath , Day Year	3. Time of Death
	Phỳsici /Madi		VANITY	MAXEY	/			JAN	16 2004	1225 M
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)			n, or Location of De		4c. County of Death	
			HOWARD COUNT	Y GEN H	SP	Ca	olumb,	A	How	PRD
	Funeral Director	2	247-70 6076	□M 200 F	rs. last birthday) Yrs.	If Under 1 Ye Months Da				place (State or Foreign ntry)
	and *		Usuel Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Aary!	ō	MD. Howard	Co	lumbia					1 ☐ Yes 2 ☐ No
	28a-	Director	10e. Street and Number			10f. Zip Cod	θ		10g. Citizen of What Cou	ntry?
	Sa or	ā	9121 Gracious I	End Ct #10	4	2104	6		USA	
	ma 2:	Funeral	11. Marital Status	12. Was Decedent Ever in				(Specify Yes or No- erto Rican, etc.)		
٥	after or Ita		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	i			ento mican, etc.)		
<u> </u>	ours a	i by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1□Yes 2□X	чо эреспу.		Specify:bla	ck
2 -C	within 72 hours after death with the Maryland ane. then "naturel", or Itama 23a or 28a-f ehow the Mudical Examination multipar all	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	dent's Usual Oc	ne during most of w	vorking	16b. Kind of Business/Ir	ndustry
7	ithin 18	ldu	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re	tired)			
2	be filed within 72 hours after death with the Marylar tal Hygiene. Id other then "naturel, or Itama 23a or 28a-1 chow of other the Medical Examination must be notified at		1.2 17. Father's Name (First, Middle, Last)		Home	maker	18 Mother's N	ame (First Middle	Wn Home Maiden Sumame)	
ב	be fi	Be								
2	should be nd Menta marked matic ev	T _o	John Jasper Go		10h Maili	na Addrage (Str		iana Gor	rdon er, City or Town, State, Zij	n Code)
M	nd 2 st lith and 27 le r r fraur					1000				
Baltimore, Maryland 21215-0036	ges 1 and 2 should t of Health and Mer if item 27 le marke or other traumatic		Antoinette Dic 20a. Method of Disposition Burial 2 Cremation 3 Characteristics of the Company	Removal from State	cemetery, cre	matory or other	Diace)	1	Bowie, and 20c. Location - City or Talverton,	
Ē	Pa Pa				arvert	Ceme	trans-			
Bal	permit. Departrimports Imports any inju		21. Signature of Funeral Service Licey	will all	55	55 Twi	n_Knolls	Road,	uneral Ho Columbia,	Md. 21045
	Physician		23a. Park. Enter the disease, or com shick, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.			FAIL		rest.	Approximate Interval Between Onset and Death
ä	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of): EUM 7	NIA				5 Days
	cuted id	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or s a cons	sequence of):					
,092	ite be executed sysician and ne burial-transit	cal	resulting in death) Last	Due to (or as a cons	sequence of):					
P.O. Box 68	The law requires that the death certificat, ate has been signed by the attending phypage 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3	⊒Ectopic pregna ⊒ Other (specify			23d. Date of deliv Month	ery Day Year
	uires that the signed by Id be detact	by	Part II. Other significant conditions of ACUTE #	contributing to death but not					obacco use contribute to	
of Vital Records,	The law requirate has been page 2 should	Completed							osy prior to co	opsy findings available ompletion of cause of
a	an: Th tificate tor, pag	e C	25. Was case referred to medical				OR Place of F	1 ☐ Yes eath (Check only o	Z No 1 Yes	26 No
5		o Be	examiner?	Hospital: Inpatient	2 ER/Outpatie	nt 3 DOA	Other		dence 6 □Other (Speci	(hu)
	ding Phys h. After this funeral di	H	27. Manner of Death 1. Natural 5 Pending	28a. Date of Injury (Month, Day Year		of 28c. i	njury at Work? 1 ☐ Yes 2 ☐ No		now injury occurred	<i>m</i>
Division	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	9 290 Place of Injury . 6	At home, farm, si ecify)	treet, factory, off	ice	28f. Location (S City or Tox	Street and Number or Rur vn, State)	al Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical C		nysician: To the best of my niner: On the basis of exan and manner stated.						
	To the within 2 To the comple	Me	29b. Signature and title of certifier				ense number		29d. Date signed (Month,	
	> - 0) (Asd	ASYMD		D=	39629		JAN 16.	2004
			30. Name and address of person who	completed cause of death (Item 23a) (Type	, Print)			, 0 /	
	6		ASYMD 10	724 4/7/	E PA	TUXENT	TALLUY	Cou	JAN 16,	mD 2004
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	18 18 18 18 18 18 18 18 18 18 18 18 18 1	1			
	Regist	rar	JAN 2 3	ZUUH Juliana	- 4 6 °	A STATE OF THE STA				

State of Maryland / Department of Health and Mental Hygiene 2 1 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 16:28 Charles Nichols Shouary 13 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bultimore Maryland University of Maryland Medical Syskem If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1ØM 2□F .77 215-22-6833 November 30, 1926 Director Maryland Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location ehow 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylat Department of Health and Mental Hygiene. Importent: If Item 27 I emarked other than 'natural, or Iteme 23a or 28s-1 ehow any injury or other traumatic event, in Medical Examtine from the inclined at 1 ☐ Yes 2X No Director MD Harford Havre de Grace 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 902 Lapidum Rd. 21078 USA Funerai 12. Was Decedent Ever in U.S. Anned Forces? 1X Yes 2 □ No If Yes, Give Year or Dates: 1945–46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th Heavy Equipment Mechanic U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 William Nichols Marie Edwards 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Linda Nichols- Daughter 1317 Aiken Ave.Ext., Perryville, MD 21903 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Mem. Grdns. 01/17/04 Aberdeen, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mitchell-Smith Funeral Home, P.A.)123 S. Washington, Havre de Grace, MD 21078 20a. Phr1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Intershipal Pheumonitis Pnysician 2 months /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed g physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No jo Month Year Day 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records. Completed 1 Yes 2 No 3 Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending s after death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funerel Director: A completely filled in by the f 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 9 o the Hospitei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) tonin Kell #15Ze1 Junuary 13, 2004 MB 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brian Killy 225. Greene St. Bultimore MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		•	For State Registrar	State of Marylan		ertificate of F		lental Hygie Reg.	_ < U U (+ 01757
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Beraldine E	. Newsome	2			2. Date of Death Month	Day Year	3. Time of Death 4 1134 M
	Examin Funeral		4a. Fecility Name (If not institution, give s 3 1 0 1 Clack SCA 5. Social Security Number 6. Sex 231 - 44 - 5958 1	_ Terr	last birthday Yrs.	Balti	or Location of Death M SYC If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay, Ye	4c. County of Dee Bult M 9. Bi	DPC City httplace (State or Foreign ountry)
34	Director		Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or L	ocation		5/01/193	8 V2	10d. Inside City Limits
	Maryla I-f sho	tor	MD N/A	100.00		imore				1X Yes 2 No
	vith the	Direc	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	ountry?
	ms 23e	Funeral Director	3101 Chelsea Te:	12. Was Decedent Ever in U	.S. 13		216 Hispanic Origin? (Sp an, Mexican, Puerto		U.S.A 14. Race - Am	
5-0036	72 hours after death with the Maryland *natural; or items 23a or 28a-f show clical Exprelimentable neithed at	þ	1 Never Married	Armed Forces? 1 □ Yes 2 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2💢 No		Hican, etc.)	Specify: B	
21215-0	c	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation a completed) College (1-4or 5+)		edent's Usual Occup e kind of work done DO NOT use retire al Worke	pation during most of work d)	ing St		MD -Dept. Services
aryland 2	be filed tal Hygi d other event, I	To Be Co	17. Father's Name (First, Middle, Last) Girney Babb	*			18. Mother's Nam	e (First, Middle, Mai Warren	den Sumame)	
lary	2 should be and Menta ls marked raumatic ev		19a. Informant's Name/Relationship (Ty Rebecca Shante'	oe, PrintDaughter				al Route Number, C		
altimore, A	Pages 1 and 2 should nent of Health and Men int: If Item 27 Is marke ury or other traumatic		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ P	20b. F	Place of Disp	position (Name of ematory or other pla			. Location - City o	
Baltin	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Licens		2	22. Name and Addre	ess of Facility Nu		eral Ho	mes, Inc.
68760,	Luxaminer bhysicien and physicien and physicien and street is the burial-transit	edical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate causa. List of userly a Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the course of	uence of):	Theorem !	V 024	auce		Approximate Interval Between Onset and Death
P.O. Box 687	To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 mpfiths? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregni 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of c	I death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of do Month	olivery Day Year
	quires that n signed b ald be deta	by	Part II. Dther significant conditions con	tributing to death but not res	ulting in the	underlying cause gr	ven in Part I.	23e. Did tobac	1 /	to the cause of death? Probably 4 Unknown
Records,	The law requir ate has been si page 2 should i	Completed						24a. Was an autopsy performed	d?/ prior to	
Vital	iclen: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:		Ott	200	h (Check only one)		
Division of	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c Inju	4 U Nursing Ho	28d. Describe how		əcify)
Divisi	el or Atter s after dea il Director ed in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, s fy)	street, factory, office		28f. Location (Stree City or Town, S		Rural Route Number,
	To the Hospitel or Attene within 24 hours after death To the Funerel Director: completely filled in by the	edical		sician: To the best of my kno ner: On the basis of examina and manner stated.				red at the time, date	and place, and du	e to the cause(s)
	To I To I	Ž	29b. Signature and title of certifier	AR THOU	10,00	29c. Licen	6146	29d.	Date signed (Mor	nth, Day, Year)
	5		30. Name and address of person who co	empleted cause of death (Iter	п 23a) (Туре	e St Ba	Mirus	ne Mis	21201	
1	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	rocked				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1- State
Registra MEND ITEM #28f PER ME G827 1/23/04 Chertificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 3:44 AM **Physician** Neuman January had 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner n/a Johns Hopkins BuyView Medical Center Bultmore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Tyrs. Months Days Hours Min. Mar 27, 1972 M1Ch1gan 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 373-78-2294 1 ☑ M 2 □ F Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 27 is marked other than "natural", or items 23a or 28s-1 show treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Md. Baltimore Dundalk Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6600 Woods Parkway Apt.2B 21222 USACompleted by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Peges 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or iter 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Porter Hotel 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael Lee Jane__VanSingel Neuman Judith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith J. Brown 19133 Dowden Circle Poolesville Md 20837 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 1/23/2004 Baltimore, Md. permit. Pege Department of Important: If eny injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski/Funeral Home, PA 21. Signature of Funeral Service Licenses Robert 1201 Dundalk Ave. Baltimore, Md 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Traumatic Injur **Physician** Brain Hours /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine physicien and the burial-transit CERTIFICAN NEPSONES Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physiclan/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Kinknown has been signed by the point of Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page performed? certificate 1 🗌 Yes 2 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1

Inpatient 2 □ ER/Outpatient 3 □ DOA 1⊈Yes 2 No After this c Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending Pedes trans Struck DV 188A 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 No investigation 2 Accident Director: / 6 Could not be determined 3 Suicide 4 | Homicide treet To the Hospital To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. DINDALK, MD edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certiful 1.0 RES-000 January 21, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue Baltinore 21224 Jon Vogel 31. Date filed (Month, Day, Year) . Registrar's Signature State MAN 2 3 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene

				Olato of M	arylana		ificate of	Death		Reg. No.	+ 01/60
	Dhuaiais		1. Decedent's Name (First, Middle,						2. Dete of Dea	ath	3. Time of Death
	Physicia /Medic			PECK					Januar	4 20 20	004 11-00 FM
	Examin	er	4a Facility Name (If not institution, g)			4b. City, Town, or l			
			St. Joseph's Nur 5. Social Security Number 6		ge (In yrs. les	t hirthday)	If Under 1 Year	Catonsvil	O Date of Diet	Baltimo:	
	Funeral Director		300-12-9442 Usual Residence of Decedent	1□M 2₺F	7.8		Months Days	Hours Min.	Jan 22,	r, Year)	Birthplace (State or Foreign Country)
	show		10a. State 10b. County		10c. City,	Town or Loca	ation				10d. Inside City Limits
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	or 28a-f	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	t Country?
	s 23s	era i	1222 Tugwell Driv	12. Was Decedent	Eura in 11 C	12 14	21228	dispenie Origin? (C		United St	ates American Indian,
980	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural; or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	Armed Forces	1		as Decedent of r Yes, specify Cub ☐ Yes 2 ☑ No	dispanic Origin? (S an, Mexican, Puert Specify:	o Rican, etc.)	Specify:	ite
5	72 hours natural',) ted	15. Decedent's	Education		16a. Decede	nt's Usual Occup	oation during most of wor d)	kina	16b. Kind of Busin	
Maryland 21215-0036	yiene.	To Be Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. Di Accoun		d)		Jewelry	
b	offie offie vent,	Se C	17. Father's Neme (First, Middle, Le	st)	,			18. Mother's Nan	ne (First, Middle,	Maiden Surname)	
<u>Va</u>	should b ind Mente i marked umatic e	٩	Joseph Zaborows	ki				Mary Os	ika		
/ar	2 sho		19a. Informant's Name/Relationship							r, City or Town, Sta	
e,	1 and Health 9m 27 ther t	-	Dr. Robert J. Te 20a. Method of Disposition	lepak MD/Ne		osque Fa	rms, NM { 20c. Location - City				
õ	ages nnt of r: If ite		1 ☐ Burial 2 ☐ Cremation 3			Tan 22					
Baltimore,	pamit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mace.		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		ess of Facility and Fune	eral Alte	Beltsvill ernatíves				
	00200		Jo Harr				Baltimo				
	Physician /Medical Examiner	*	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARCÎNOMA 4 the Lung Due to (or as e consequence of): Brain Metastasis								Approximate Interval Between Onset and Death
	nsit	盲		b. BY	ain	(VIE	Tastas	13			three Months
ox 68760,	requires that the death certificate be executed been signed by the attending physician and hould be detached for use as the bunal-transit	Medic	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or a	s a consequ					
Box	daath cer e attandir d for use	cla	Part II. Other algnificant conditiona	contributing to death I	ut not resulti	ng in the unc	terlying cause di	ven in Part I	23b. Did t	obacco uae contrit	oute to the cause of death?
P.0	t tha da by the a tached	by Physician/		eimers			,g g.				Probably 4 Unknown
	es tha igned be da	by	HIZA	ermens	21/1	ease					
ecord		Completed			-				24a. Was a perfor	an eutopsy 2. med?	4b. Were autopsy findings available prior to completion of cause of death?
æ	sicien: The law cartificate has b irector, page 2 s	E							104	00 2 1Nc	1 ☐ Yes 2 ☑ No
/ita	artifica actor,	Be	25. Was case referred to medical examiner?				l'ai	A	th (Check only o		
) 	his h	2	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati		NOutpatient	3LI DOA			ence 6 Other (Specify)
n	age age	27. Manner of Death 1 Mineturel 5 Pending (Month, Dey Year) 1 Denote the investigation 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Pending (Month, Dey Year) 1 Pending 1 Pendi							28d. Describe n	ow injury occurred	
Division of Vital Records,	or Attendation death Director:	ertifical	2 Accident Investiget 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of In	jury - At homic. (Specify)	e, farm, stree	et, factory, office	700 2010	28f. Location (S City or Tow		or Rural Route Number,
₹	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely fillad in by the f	edical Certification:		Physician: To the best aminer: On the basis of and manner s	f examination						
	To the comple	¥	29b. Signature and title of certifier	Called	,		29c. Licens	se number 30469	3	29d. Date signed (N	10nth, Day, Year) 2004
	'/		30, Name and address of person wh	completed cause of	deeth (Item 2)	3a) (Type, P	rint) DR	· SVI	(00 : E	MICOTT (21, 2004 ady - MD 21042
	Stat		31. Date filed (Month, Day, Year)	32. Regist	rar's Signatur						•
	Registra	ar	IAN 2 3 2004	Beneda	19	do	ake				

DHMH 16 Rev 6/95

ORIGINAL

			A POI	partment of Health and M Certificate of Death		ene 2004	01761	
	Dhusisi		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death	
. 4	Physici /Medic		Helen Mae Pratt		01-21	-2004	9:30PM	
S. Salar	Examin	er	4a. Facility Name (If not institution, give street and number) Sinai Hospital	4b. City, Town, or Location of Death Baltimore		4c. County of Death		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Davs Hours Min.	8. Date of Birth (Month, Day,) July 25,	(ear) 9. Birth Coul 1907 Mar	place (State or Foreign http: Vland	
			Usual Residence of Decedent					
	show	ž	10a. State 10b. County 10c. City, Town o				10d. Inside City Limits 1√⊒Yes 2 □ No	
	the M	Director	Maryland n/a Ba	timore 10f. Zip Code	100	g. Citizen of What Cou		
	3a or	10	2211 W. Rogers Avenue	21209		United S	-	
	death	Funeral [13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri	can Indian,	
21215-0036	72 hours after death with the Maryland neturel', or items 23a or 28e-f show disal Examinar must be notified at	by Fu	1 Never Married 2 Married 1 Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	nican, etc.)	Black, White,	white	
5-0	"neturel", "dical Ex	eted	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	ecedent's Usual Occupation live kind of work done during most of worki ie. DO NOT use retired)	ing 16	6b. Kind of Business/In	dustry	
121		Completed by	Elementary/Secondary (0-12) College (1-4or 5+)	o. DO NOT uso retired) Homemaker		Own Ho	amo.	
d 2	filed Hygi ther		17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		iiie	
Maryland		To Be	Charles Johnson	Alice	e Sadl	er		
<u>a</u>	d 2 should th and Men 7 Is marke traumatic	. 5		ailing Address (Street and Number or Rura			-	
77	C - N -					t, Marylan		
0	0 0 = 5		1 A Buttal 2 Colemation 3 Chemoval from State	crematory or other place)		oc. Location - City or To		
Baltimore,				od Cemetery Jan. 2 22. Name and Address of Facility	24,2004	Baltimore 05 Harford	, Maryland	
Ba	permit. Departr Importe any inju		21. Signature of Funeral Fervice Coases Michael E. Canapp	Leonard J. Ruck. 1		Itimore, M		
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.				Approximate Interval Between	
1	Physician		Immediate Cause (Final disease or condition Acute CA	RDIAL DYSKHY	THMIA		Onset and Death	
1	/Medical Examiner		resulting in death) Due to (or as a consequence of):			,	2.16	
Н		2	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of the consequence	OCAJUDIAL INF	ARCTION	J	DAYS	
J	uted 1 ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	E CARPIO VASCUA	AR I	DISCASE	YEARS	
oʻ	exect an and rial-tra		resulting in death) Last Due to (or as a consequence of):	C Citi-File of Ody	-1115			
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the bunal-transit	edical	d					
	feath certifica attending ph for use as the		IF FEMALE:					
Вох	attenc for us	lan	in the past 12 months?	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delive Month	ery Day Year	
P.O.	at the de by the tached	Physician/M	1 ☐ Yes 2 No 9 ☐ Unknown	3 Citier (specify)				
	res that igned b be deta	by Pi	Part II, Other significant conditions contributing to death but not resulting in the		23e. Did toba	cco use contribute to the	ne cause of death?	
ord	w require been sig should b	ted	RESEART GASTRO INTESTINAL	BLAFD	1 ☐ Yes	2 No 3 Prob	pably 4 Unknown	
Vital Records,	e law r has be ge 2 sh	Completed			24a. Was an autopsy	prior to co	psy findings available impletion of cause of	
al H	ien: The l intificate ha					d2 death? No 1 ☐ Yes	2 No	
Z:	sicien: certific irector,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ER/Outpa	Other	(Check only one)	ce 6 Other (Specif		
of	g Phys ter this neral di	n: To	27. Manner of D ath 28a. Date of Injury 28b. Tim	e of 28c. Injury at	28d. Describe how		/)	
ion	ttending I death. ctor: After y the funer	atlo	2 Accident investigation	M 1 Yes 2 No				
Division	Hospitel or Attending Physicien: 4 hours after death. Funerel Director: After this certificately filled in by the funeral director, tely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	streel, factory, office	28f. Location (Stre City or Town,	et and Number or Rura State)	l Route Number,	
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, d	eath occurred at the time, date and place, a r investigation, in my opinion, death occurre	and due to the cau ed at the time, date	se(s) and manner as s and place, and due to	ated. the cause(s)	
	To the within 2 To the complet	M	29b. Signature and title of certifier	29c. License number	290	I. Date signed (Month,	Day, Year)	
	10		Holes E. Kolymo.	D-1942S		1/22/04	<i>t</i>	
	18		30. Name and address of person who completed gause of death (Item 23a) (Ty Ro B (M.T. F. Ro B') M.D221/	Pe, Print) W. ROGERS A	ve- B	ALTO, MD	21209	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Senature 2 3 2024	& food		7		

Physici		1. Decedent's Name (First, Middle, Las				2. Date of Deat Month	19,2004	3. Time of Death
Physicia /Medic	al	Mary Pe		PETTIFORD		Jen .	20 200	0,7,0
Examin	er	4a. Facility Name (If not institution, give	street and number)	4b. Cir	, Town, or Location of Deal	th	4c. County of Dea	/
			ex 7. Age (In yrs. Ia	est hirthday) If Und	er 1 Year If Under 24 Hrs	8. Date of Birth	10HC	thplace (State or Fore
Funeral Director			M 2/2 F 1. Age (117 y 13. 12	Yrs. Months			Year) C	ountry) T
nector	.	Usual Residence of Decedent					, 0	
how		10a. State 10b. County	10c. City,	, Town or Location				10d. Inside City Lim
a-la liffer	ctor	MO BOLL.	nene Pik	esville				1 Tes 2 2
or 28	Dire	10e. Street and Number		10f. Z	ip Code	1	0g. Citizen of What C	ountry?
nt of Health and Mental Hygiene . If Item 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic avent, the Medical Exemples	Funeral Director	8813 Stan-	CR-DJE C	· rele	21208	S	14. Race - Am	nden Indian
Item Inc.	une	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	If Yes, sp	edent of Hispanic Origin? (S ecify Cuban, Mexican, Puer	to Rican, etc.)	Black, Whi	
r, or	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🗹 Divorced	1 ☐ Yes 2 🗖 No If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify:	3/Act
atura cal E		15. Decedent's Ed	ucation	16a. Decedent's Us	ual Occupation	di-	16b. Kind of Business	/Industry
Media	pie	(Specify only highest gra	College (1-4or 5+)	life. DO NOT	vork done during most of wo use retired)	nking		
er th	Completed	12		Don	nestic			
d oth	Be (17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle, f	Maiden Sumame)	
nd Mental Hygiene. marked other than imatic avent, tha Mi	ပ္	Harold Pettil	ord		Killa	· Ver	tures	
is m		19a. Informant's Name/Relationship (7	- 6	19b. Mailing Addre	ss (Street and Number or R	W 0.		
Department of Health Important: If Item 27 any injury or other tr once.		20a. Method of Disposition	NZie /UrughTer	ace of Disposition (N	one side Cito	ALC: NO PERSON NAMED IN COLUMN TWO IS NOT THE OWNER.	Ville MD 20c. Location · City of	7/208
or of the		1 ⊠Burial 2 ☐ Cremation 3 ☐	Removal from State / CO	metery, crematory of	other place)		2011	- M A
epartment nportant: ny injury o nce.		*4 Donation 5 Other (Specify	100	udon 1-6	and Address of Facility	6-04	39 Ctimor	0500000
Depar Impor any ir once.		21. Signature of Funeral Service Licen	S00	22. Name	and Address of Facility	Da (. 6-1	/	
		23a. Part1. Enter the disease, or comp	plications that caused the death	Do not enter the m	ode of dving such as cardia	c or respiratory arr	town, MO	Approximate
ysician		shock, or heart failure. List only immediate Cause (Final						Onset and Death
Medical		disease or condition resulting in death)	a. Due to (or as a consequ		Doguerse			
aminer		A STATE OF A STATE OF	b. Cornor	or clasth.	2			
===	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Deuto (or as a consequ	arine of)				
ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Hygurlun					
ysician a ne burial-	al Ex	1830 kmg m Gdatriy Last	Due to (or as a consequ	ence or):				
he	<u>.0</u>		d					
attending pt I for use as t	by Physician/Med	IF FEMALE:	23c. If yes, outcome of pregnar	nev			22d Date of de	divone
attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal	death 3 ☐ Ectopic			23d. Date of de Month	Day Year
the	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown	3 0 0 0 1101 (specify/			
	y Ph	Part II. Other significant conditions c	ontributing to death but not resul	Iting in the underlying	cause given in Part I.	23e. Did tot	pacco use contribute t	o the cause of death
ed by the a detached f						1 🗆 Ye	s 2 No 3 P	robably 4 Unkn
ار او	iete					24a. Was a	n 24b. Were a	utopsy findings avail
peen sign hould be						autops	ned? death?	
peen sign hould be	dwo				26. Place of De	1 ☐ Yes a		5 90 110
peen sign hould be	e Completed	25. Was case referred to medical			Othor		ence 6 Other (Spe	ecify)
s certificate has been sign director, page 2 should be	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 E	ER/Outpatient 3□ I		28d. Describe ho	w injury occurred	
this certificate has been sign al director, page 2 should be	To Be	examiner? 1 Yes 2 No 27. Manner of Death	1 Inpatient 2 E	28b. Time of	28c. Injury at Work?			
n. Affer this certificate has been sign funeral director, page 2 should be	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)		28c. Injury at Work? 1 ☐ Yes 2 ☐ No			
n. Affer this certificate has been sign funeral director, page 2 should be	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hor	28b. Time of Injury M	1 ☐ Yes 2 ☐ No	28f. Location (St City or Town	reet and Number or F	lural Route Number,
n. Affer this certificate has been sign funeral director, page 2 should be	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	1 ☐ Yes 2 ☐ No	28f. Location (St City or Town	reet and Number or F n, State)	lural Route Number,
n. Affer this certificate has been sign funeral director, page 2 should be	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hor building, etc. (Specify, ysician: To the best of my know	28b. Time of Injury M me, farm, street, fact) wledge, death occurre	1 ☐ Yes 2 ☐ No ory, office Indicate the time, date and place	City or Town	n, State) ause(s) and manner a	s stated.
n. Affer this certificate has been sign funeral director, page 2 should be	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier (Check only one) 1 Certifying Ph.	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hor building, etc. (Specify, ysician: To the best of my know	28b. Time of Injury M me, farm, street, fact) wledge, death occurre ion and/or investigation	1 ☐ Yes 2 ☐ No ory, office and at the time, date and place on, in my opinion, death occ	City or Town	n, State) ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
fter this certificate has been sign neral director, page 2 should be	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hor building, etc. (Specify, ysician: To the best of my know	28b. Time of Injury M me, farm, street, fact) wledge, death occurre ion and/or investigation	1 ☐ Yes 2 ☐ No ory, office Indicate the time, date and place	City or Town	n, State) ause(s) and manner a	s stated. e to the cause(s)
n. Affer this certificate has been sign funeral director, page 2 should be	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	28a. Date of Injury (Month, Day Year) 28e. Place of Injury · At hor building, etc. (Specify, ysician: To the best of my know niner: On the basis of examinati and manner stated.	28b. Time of Injury M me, farm, street, fact) wledge, death occurre ion and/or investigation	1 ☐ Yes 2 ☐ No ory, office and at the time, date and place on, in my opinion, death occ	City or Town	n, State) ause(s) and manner a ate and place, and du	s stated. e to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) A.K.A. WALTER T. PACHULSKI Month WALTER T. PACHOLSKI 1:19 January 20 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Franklin Souare Hospital Rose Baltimore Center 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) /ear 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Days 1⊠M 2□F Months Hours Min. 217-16-3746 86 9/5/1MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No BALTIMORE DUNDALK 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7922 DIEHLWOOD ROAD 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Nes 2 No If Yes, Give Year or Dates: WW II 1 ☐ Yes 2/ No Specify: Specify: 3 Widowed 4 Divorced WHITE 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TUG BOAT 6 0 TUG BOAT ENGINEER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) VINCENT PACHOLSKI ANNA JANKIEWICZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MD. MRS. HELEN G. PACHOLSKI 7922 DIEHLWOOD RD. 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State HOLY ROSARY CEME. 1/23/04 DUNDALK, MD. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses KACZOKOWSKI FUNERAL HOME P.A. Sodar Tohns 1201 DUNDALK AVE. BALTIMORE. MD. 21222

Physician /Medical

Physician

/Medical

Examiner

10a, State

MD

Funeral

Director

frems 23a or 28a-f ehow frer must be notified at

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other traumatic avent, the Mudical Examiner

1 and 2 should be filed within Health and Mental Hygiene. em 27 is merked other than

Health

Baltimore,

o

Records,

Vital

of

Division

Department of Healt Important: If item 2 any injury or other ance.

Funeral Director

Completed by

Be

Examiner

Examiner burial-transit and physician Physiclan/Medical the 38 attending properties as signed by the a by Completed peeu page 2 s has certificate 2 funeral dir this After

the death certificate be executed Certification: or Attending s after death. Il Director: Aft ad in by the fur filled in by within 24 hours a Hospitel Medical

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

1 ☐ Yes 2 ☐ No

9 Unknown

in the past 12 months?

IF FEMALE:

Pneumonio Due to (or as a consequence of): Due to for as a consequence of Due to (or as a consequence of):

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4☐Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23e. Did tobacco use contribute to the cause of death?

26. Place of Death (Check only one)

Day Year

3 Probably 4 Unknown

23d. Date of delivery

Month

Approximate Interval Between Onset and Death

weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

Myocardial Infarctio	r
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1 🗌 Yes 2 No 24a. Was an autopsy performer? 1 ☐ Yes 2 No

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 2X No 1 🗌 Yes Manner of Death
Natural
Accident

5 Pending investigation 6 Could not be

determined

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year)

and manner stated

2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 Tes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

DC057573

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

3 🗌 Suicide

29a. Certifier

4 Homicide

2004 1AM 2 3



AKG			1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death									* O	1764			
			Decedent's Name (i	First, Middle, Last,)							2. Date of De. Month				ne of Death
	Physicia /Medica		Rom	el			Pit	tman				Januar		5, 2004	10	:13 P
	Examine		4a. Fecility Name (If no	-		r)		7,		Location	of Death		40	: County of De NA	ath	
			2402 East 5. Social Security Num			ne /ln vrs	last birthday)	Bal1	Limo. 1 Year	re If Under	24 Hrs.	8 Date of Birt	th		rthnlace (S	ate or Foreign
	Funeral Director		215-78-39	*F	1	30	Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da 12-6-	y, Year) -73		ountry)	ate or Foreign
	g		Usual Residence of D	ecedent		T										4. 00. 11.
	arylar		10a. State 1	0b. County		10c. Cit	ty, Town or Lo									de City Limits Yes 2 ☐ No
	Ne M	Director	Md. 10e. Street and Numb	NA NA			Balt	imore 10f. Zip	Code				10a Ci	tizen of What C		
	72 hours after death with the Maryland Instural, or items 23a or 28a-1 show dieal Exeminer must be notilized at	ᄒ	2330 E.		reet			101. 2.10		21205	5			USA		
	death	by Funeral	11. Marital Status		12. Was Deceden	t Ever in U	J.S. 13.	Was Deced	ent of Hi	spanic Or	igin? (Spe	ecify Yes or No Rican, etc.)	-	14. Race - An		ın,
9	or ite	Ē	1X Never Married	2 Married	Armed Forces 1 ☐ Yes 2 If Yes, Give] No		ii ves,spec 1 ⊟ Yes 2		Specify:		rican, etc.)		Black, Wh		
003	ural',	d b	3 Widowed 4		Year or Dates	:									lack	
15-	n 72 h	lete	(Specify	5. Decedent's Edu only highest grad	e completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	l Occupa k done d e retired	ation <i>during</i> mos i)	st of worki	ing	16b. K	(ind of Busines	s/Industry	
12	withi iene. r then	Completed	Elementary/Second 12th grade		College (1-4or	_	1	Labore					i	Mason		
<u>5</u>	e filed of her vent,	Be C	17. Father's Name (Fi							18. Moth	er's Name	(First, Middle,	Maider	Sumame)		·
<u>la</u>	Menta Menta arked atic a	2	Sidney			Wh	ite, J				ette			Pittm		
lan.	2 sho and Is my	H	19a. Informant's Nam		•							I Route Numbe				
6	Health Health Tem 27	-	Yvette P 20a. Method of Dispos		Mother	20b. F	Z / 3 Place of Dispo			Ave.		ltimore		d. 212		te
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic avent, the Madical Examiner mast be notified at once.		1 Surial 2 🗆	Cremation 3 □F	Removal from Stat		cemetery, cre rbutus	matory or of	her plac		L-24-			butus ,		
謹	artme orteni injury	1	' 4 ☐ Donation 5					2. Name an				Baltin			21202	
B	permii Depar Impor any ir		Mere	und C	1-			March	F.H	. Eas	st				Ave.	
			23a. Part 1. Enter the shock, or heart	disease, or comp	lications that caus	ed the dear	th. Do not en	ter the mode	of dyin	g, such as	cardiac o	or respiratory a	rrest,			l Between
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	/Medical Examiner		resulting in death)		Due to (or a			440				, ,				
	A Sac	_	Sequentially list cond	itions,	b. Due to (or a	e a martine	summer off								-	
	pel list	Examiner	Sequentially list cond if any, leading to infini- cause. Enter Underly Cause (Disease or inj	ring dury	D09 13 (01 9	is a compac	quence on.									
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8760,	cate be executed ohysician and the burial-transit	cal			d											
ယ	ns phy as th	Ved	IF FEMALE:												-	
Вох	The law requires that the deat "cert fice ate has been signed by the attending phoage 2 should be detached for use as the	Physician/Medical	23b. Was decedent p	regnant	23c. If yes, outcom 1 ☐ Live birth	2 ☐ Feta	al death 3	⊒Ectopic pre						23d. Date of di Month	elivery Day	Year
O.	the at	sic	1 Yes 2 1		4□Pregnant 9□Unknown		death 5[Other (sp	ecify)						54,	
Division of Vital Records, P.O.	uires that the de signed by the a Id be detached f	H.	Part II. Other significa	ant conditions co	ntributing to death	but not res	sulting in the u	inderlying ca	ause give	en in Part	1,	23e. Did t	obacco	use contribute	to the cause	e of death?
ds,	uires n sign	d by			-							10	Yes 2	X 00 3□	robably	4 🗆 Unknown
COL	w require	Completed										24a. Was		24b. Were a	autopsy find	ings available
Re	The lavate has	ошо									-	autor perfo	rmed?	death?	completions 2 No	of cause of
ta		Be C	25. Was case referred	d to medical						26. Place	e of Death	(Check only o		, , ,		
> _	Attending Physicien: r death. ector: After this certifics by the funeral director, I	70	examiner? 1 XX es 2 □ No	•	Hospital: 1 ☐ Inpa] ER/Outpatie			7 🗀 141		me 5 Resi			ecify) At	scene
u o	ing P	on:	27. Manner of Death 1 □Natural	5 Pending	28a. Date of In (Month, L		28b. Time o		Bc. Injury Work			28d. Describe		iny occurred いれら ろ)	(at	
isio	death.	icat	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not be	January 15		10:06	P M		Yes 2 🕽		28f. Location (Number
Ď	i gite	Certification:	4 Homicide	determined	28e. Place of I building,		street	ioot, iactory	, 011100			City or To	nn, Stati	e)	Ralt	more
	spita nours neral / filled				rsician: To the bes	st of my kn	owledge, deat					and due to the	cause(s	and manner		MD
p	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 one)	Medical Exam	iner: On the basis and manner		ation and/or in	ivestigation,	in my o	pinion, dea	ath occurr	ed at the time,	date an	d place, and du	ie to the ca	use(s)
	To the To the Comp	Σ	29b. Signature and tit	le of certifier	4			290	. License	e number			29d. Da	te signed (Mor	nth, Day, Ye	ar)
	0		Jasi	has)	treets	ey.	ND		.C.M	.E.			Jan	uary 16	, 200	4
	in		30. Name and address	1		death (Ite	т 23а) (Туре,			O.		D-144		Mar 7	_3 21	201
	Stat	i Q	31. Date filed (Month,		16 era N	strar's Sign		111	renn	Stre	æt,	Baltim	re,	Mary 1	uxi 21	ZUI
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			1_ For	State of Ma		artment o		Mental Hy	giene 2004	01765
			Registrar 1. Decedent's Name (First, Middle, Last	1		runcate	Dealli	2. Date of Dea	Reg. No.	3. Time of Death
	Physici	an						Month	Day Year	12:30 PM
	/Medic		Grace Miller 4a. Facility Name (If not institution, give			4b. City, Tow	m, or Location of De	January ath	7 21, 2004 4c. County of Dee	
	Examin	er	1939 Glen Cove				arlington		Harford	
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthday) If Under 1 Y		rs. 8. Date of Birt		thplace (State or Foreign ountry)
	Director		213-78-0819	⊒м 2 Д уЕ	90 Yrs.	Months	ays riodis ivi	Aug. 26		nnsylvania
	p .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	anyla shov	5			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					1 ☐ Yes 2 ☐ XNo
	the N	Director	Maryland Harford 10e. Street and Number		Darii	ngton 10f. Zip Co	de		10g. Citizen of What C	ountry?
	with Be or		1939 Glen Cove	Road			1034		USA	
	within 72 hours after death with the Maryland ane. than "natural", or Itams 23e or 28e-f ehow ta Madical Examirer: and be notified at	Funeral	11. Marital Status	12. Was Decedent Ev	ver in U.S. 13		of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No		
9	or Ita	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 Ø		ento rican, etc.)	0	
215-0036	"natural", or	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:						White
5-0	72 h	Completed	15. Decedent's Ed (Specify only highest grad		(Giv	edent's Usual O e kind of work d DO NOT use re	one during most of v	vorking	16b. Kind of Business	s/Industry
121	within ane.	m	Elementary/Secondary (0-12)	College (1-4or 5+	.)	nemaker	stiredy		Own Hom	e
d 21	Hygie Hygie other	ပိ	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle,	Maiden Sumame)	
lan	id be ental ked c	To Be	Christian A. K	arr			Elma	Nookumer	Miller	
Maryland	s 1 and 2 should be filed within 72 hc If Health and Mental Hygiene. Item 27 Is marked other than "natural other traumatic event, the Madical		19a. Informant's Name/Relationship (7		19b. Mai	ling Address (St			er, City or Town, State,	Zip Code)
	1 and 2 Health a em 27 la		Marie Olinger / D	aughter	1939	Glen C	ove Road,	Darlingt	on, Maryla	nd 21034
Baltimore,	es 1 and of Health		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Disp cemetery, cre	oosition (Name of ematory or other	of r place)	Date	20c. Location - City of	Town, State
Ë	permit. Pages Department of t Important: If Ite sny injury or of		'4 □Donation 5 □ Other (Specify		Darlingt			31-04	Darlington	, Maryland
alt	permit. Pa Departmer Important sny injury once.		21. Signature of Funeral Service Licent	sêe /		22. Name and A McComas	ddress of Facility Funeral	Home, P.A	A.	
ш	205 a		Janes 11 11	nyof		1317 CC	keshury R	Road. Abir	nadon. Mary	land 21009 Approximate
2			23a. Fait1. Enter the disease, or comp shock, or heart failure. List only	ine cause on each line	ne death. Do not e	nter the mode of	oying, such as card	nac or respiratory ai	rrest,	Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. ends	K .	ment	7			
	Examiner			Due to (or as a	consequence of):					
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	nonságuanna s/):					
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oʻ	be executed iicien and burial-transil		resulting in death) Last	Due to (or as a	consequence of):					
3760,	ate be hysici he bu	lical		d						
(68	requires that the death certificate be executed seen signed by the attending physicien and hould be detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE:	23c. If yes, outcome of	f program	- 3				
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at t	Fetal death 3	☐Ectopic pregr			23d. Date of de Month	Day Year
	he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	inte or death 5	Other (specia	y/			
P.O.	res that I signed by be deta	Y Ph	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the	underlying caus	e given in Part I.	23e. Did t	obacco use contribute	to the cause of death?
Vital Records,	puires n sign	d b	still fluid	lele.				_ 10`	Yes 2□No 3□F	robably QUnknown
000	> Q 70	lete	*					24a. Was	an 24b. Were a	utopsy findings available
Re	9 4 9	mo						 autor perfo 1 Yes 	rmed? death?	
ta	ician: Th certificate ector, pag	0	25. Was case referred to medical				26. Place of 0	Death (Check only o		
1	sys	To B	examiner? 1 ☐ Yes 2 ☑ No		nt 2 ER/Outpati	ent 3 DOA	Other: 4 Nursing	g Home 52 Resi	dence 6 □Other (Sp.	ecify)
0	ng Ph fter th nerai	no.	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injun (Month, Day	Yeer) 28b. Time Injury		Injury at Work?	28d. Describe	how injury occurred	
Sio	eath. or: A	cati	2 Accident investigation 3 Suicide 6 Could not be			М	1 ☐ Yes 2 ☐ No	0011		
Division of	or Att	Certification:	4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, s . (Specify)	street, factory, of	ffice	City or To	Street and Number or F wn, State)	tural Houte Number,
	pital ours a eral C	Ce	29a. Certifier Certifying Ph	veician. To the best o	l my knowledge de	ath occurred at t	he time, date and ni	ace, and due to the	cause(s) and manner a	is stated
	24 hc 24 hc Fun etely	edical			examination and/or				date and place, and du	
	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	₩.	29b. Signature and title of certifier			29c. L	icense number		29d. Date signed (Mor	nth, Day, Year)
	F > F 0		Danel	D		D	32211		SANUACT	22 2004
	3		30. Name and address of person who			e, Print)	1			
			DAVID 5 DUN	2 615	w. Me	oc Pho.	1) Qc/	our ma		
		ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature					
	Regist	rar	JAN 2 3 2004							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene?

		1 - For State Registrar		Certificate of Death		ag. No.	U1/00
Physici	ian	Decedent's Name (First, Middle, Las			2. Date of Deat Month	Day Year	3. Time of Death
/Medi		4a. Facility Name (If not institution, give	Martha N. Rob	1nson 4b. City, Town, or Location of E	L Death	16 2004 4c. County of Deeth	11:27 a. ^M
Examir	ier	Villa St Michae		Balto		N/A	
Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last t	pirthday) If Under 1 Year If Under 24	Hrs. 8. Date of Birth Min. (Month, Day,	Year) 9. Birthp	ace (State or Foreign
Director		256-46-0/46	□M 2XIF 74	Yrs.	12-17		Ga
and *		Usuel Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location		11	Od. Inside City Limits
f sho	ō	Md N/A	Ba1	to			Y∏Yes 2 No
28s-	rect	10e. Street and Number		10f. Zip Code	11	Og. Citizen of What Coun	try?
death with the Maryland ime 23a or 28a-f show r roust be notified at	ai D	10 Mount Batten	Ct	21207		USA	
me a	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Americ Black, White,	
filed within 72 hours after Hygiene. kther then "neturel", or Ite but, It'e Medical Exeriline	by Fu	1 Never Married 2 Married	1 ☐ Yes 2X No If Yes, Give	1 ☐ Yes 2¶ No Specify:	, ,	Specify:	Black
hours tural!		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	a Decedent's Heual Occupation		16b. Kind of Business/Ind	
in 72 n na n	Completed	(Specify only highest gra	de completed)	 Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) 	f working	Cosmetolo;	-
i with	E O	Elementary/Secondary (0-12) 12th grade	Cotlege (1-4or 5+) 2 Years	Self Employed	9	COSME COTO	51.56
e filed at Hygin other vent, I	BeC	17. Father's Name (First, Middle, Last)		18. Mother's	Name (First, Middle, M	faiden Sumame)	
Menta Menta arked arked	To E	Len Ramsey		Willi	le Mae Sul	livan	
ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. It filem 27 is marked other than "natural", or iteme 28a or 28a-f show or other traumatic event, if a Medical Examinat mast be notified at	1	19a. Informant's Name/Relationship (7	ype, Print)	b. Mailing Address (Street and Number of	or Rural Route Number,	City or Town, State, Zip	Code)
lealth lealth im 27 her tr		Alvin Robinson, 20a. Method of Disposition	Jr - Son 20h Place	5709 E. Moenerald of Disposition (Name of	Oaks Drive	Acworth, (a 30102
Pages 1 nent of H int: if ite iry or ot		1 Burial 2 □ Cremation 3 □	nemoval nom State	ery, crematory or other place)			wii, State
그 돈 된 글		* 4 ☐ Donation 5 ☐ Other (Specify 21. Sign turn of Funeral Service Licen		ilawn Cemetery 1/		Balto, Md	
Depa Impo	1.	21. Sign to 1017 diteral service Electric	Sal a la		•	west nue Balto, M	m 21215
==10		23a. Parl1. Enter the disease, or com	olications that caused the death. D	o not enter the mode of dying, such as ca			Approximate
hysician		Immediate Cause (Final	one cause on each line.	Demen			Interval Between Onset and Death
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and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.	D			
cian a	E	rosaling in doutily East	Due to (or as a consequence	9 OF):			
physician and s the burial-transit	edical		d		-		
oding Ise as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy		55	23d. Date of delive	rv
atter d for u	ician/M	in the past 12 months?	1 Live birth 2 Fetal dea 4 Pregnant at time of death	th 3 Ectopic pregnancy 5 Other (specify)		1	Day Year
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en siç Juld b					1Ye	s 2 □ No 3 □ Prob	ably 4 @Unknown
as be 2 sh	ompieted				24a. Was ar autops	24b. Were autor	sy findings available
page 2	Con				perform 1 ☐ Yes 2	ned? death?	. /
certificate rector, pag	Be	25. Was case referred to medical examiner?	112-1	0.1	Death (Check only one		
n. After this certific funeral director,	2	1 ☐ Yes 202 No	Hospital: 1 Inpatient 2 ER/			nce 6 Other (Specify)
n. After this funeral di	Certification;	27. Manner of Death 1 ☐ Matural 5 ☐ Pending	(Month, Day Year)	. Time of 28c. Injury at Injury Work? M 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurred	
death stor:	icat	2 Accident investigation 3 Suicide 6 Could not be				reet and Number or Rura.	Route Number
Dire Dire Tin by	ertif	4 ☐ Homicide determined	building, etc. (Specify)	ram, street, ractory, onles	City or Town	, State)	
within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edicai C	(Check only 2 Medical Exam	niner: On the basis of examination	ge, death occurred at the time, date and pand/or investigation, in my opinion, death	place, and due to the ca occurred at the time, da	use(s) and manner as st ate and place, and due to	ated. the cause(s)
(V) 00 00	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License number	29	9d. Date signed (Month, I	Day, Year)
E P					-	· · · · · · · · · · · · · · · · · · ·	,,,
To the		1.1		1 1	,	12:10.1	
within To the compl	د	30 Name and address of acceptance	completed cause of death/liver 22	O DITY2	1 /	121/04	
within within to the comp	ر	30. Name and address of person who D; ill & B. MVE	completed cause of death (Item 23a 412, Co	1) (Type, Print) man wealth	AV cox	(21/04 www.ll+111	1 2177.8

State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 30 AM 260 RINGER anualy /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a_Facility Name (If not institution, give street and number) **Examiner** H65P1 Rosedale Ba TIMOI Soluale 2/K/1 0-If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 7/9/1934 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1XXM 2□ F 69 WĔŚŤ Yrs 232-56-6956 VIRGINIA Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exertition must be notified at 1 ☐ Yes XX No Director MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ 910 KINWAT AVENUE 21221 U.S.A. or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 Never Married XX Married 1 ☐ Yes 2XXXVo Specify: WHITE þ Specify: 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 12 PLUMBING FOREMAN SOCIAL SECURITY ADMIN. of Health and Mental Hygie item 27 Is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be LULA G. RODEHEAVER FRANK ERNEST RINGER 19a. Informant's Name/Relationship (Type, Print) Ringer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 910 KINWAT AVENUE, BALTIMORE, MARYLAND 21221 NAOMI RINGER - WIFE altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of H
Importent: If ite
any injury or of XX Burial 2 Cremation XX Removal from State SHADY GROVE CEMETERY 1/19/2004 BRUCETON MILLS, WV 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service 12, see FINK 22. Name and Address of Facility MARYLAND MORTUARY / FINK FH PA #M01148 426 CRAIN HIGHWAY SOUTH, GLEN BURNIE, MD 21061 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) montle cell Lymphoma Advoraged Physician 8 months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, by leading 13 immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consuluence of) Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760 attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.O. 1 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 X No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification; To 2 ER/Outpatient 3 DOA After the ate of Injury (Month, Day Year) 28b. Time of 27. Manner of Seath 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No death. within 24 hours after death To the Funeral Director: filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Dev. Year) 101 29b. Signature and title of certifier 15/04 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1. Loura Steele rive Baltimore Franklin Square 31. Date filed (Month, Day, Year) 32. Raistrar's Signature State Registrar

		•	1 - For State Registrar	State of Maryla	nd / Depa <i>Cer</i>	irtment of <i>tificate o</i>	Health and f Death	Mental Hy	/giene/ Reg. No.	2004	01768
Dh	·		1. Decedent's Name (First, Middle, Last)	2			-	2. Date of D Month	eath Day	Yeer	3. Time of Death
	ıysici: Medic		WILLIAM	RUANE				JAN	19	2004	4:00 PM
Ex	camin	er	4a. Fecility Name (If not institution, give s				or Location of Dea			County of Death	
			GOOD SAMARITAN HO 5. Social Security Number 6. Sex		. last birthday)	If Under 1 Yea	MORE CITY or If Under 24 Hr			N/A	place /State or Foreign
	neral ector			M 2□F 73	Yrs.	Months Day			ay, Year)	MARY	place (State or Foreign ntry) 'LAND
	.0101	l	Usual Residence of Decedent	17	1			10/50/	7,50	1	
rylan	3		10a. State 10b. County		ity, Town or Lo						10d. Inside City Limits
e Ma	dilla	Director	MD N/A		BALTIMO						1 🖾 Yes 2 🗆 No
vith th	20	Dire	10e. Street and Number		100	10f. Zip Code				en of What Cou	intry?
s 23e	Take.	Funeral	1651 E. BELVEDERE	AVENUE APT 2. Was Decedent Ever in		212	39 f Hispanic Origin? (Specify Vos or N	USA	4. Race - Ameri	can Indian
ter de	No.	-un	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1⊈TYes 2 □ No	0.3.	Yes, specify Co	uban, Mexican, Pue	erto Rican, etc.)	0-	Black, White	
urs al	Exam	þ	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates KORE	AN	☐ Yes 2X N	o Specify:			Specify: WH]	TE
If a reference of the management of the management of the management of the management of them 23e or 28e-1 show	event, the Medical Examiner must be notified at	Completed	15. Decedent's Educ		16a. Deced	ent's Usual Occ	upation ne during most of w	odkina	16b. Kin	d of Business/Ir	ndustry
ithin it	Meg	nple.	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use reti					
led w lygier her th	4		12TH GRADE 17. Father's Name (First, Middle, Last)		DRA.	FTSMAN	40 Mathada N	(Fina Adiable	AF		
y ial IC buld be fi Mental H arked ot	9	Be	WILLIAM A. RUANE,	SR.			CLEMEN	ame <i>(First, Middle</i> TINE		LLABLE	
d 2 should be file th and Mental Hy 17 Is marked oth	=	ဥ	19a. Informant's Name/Relationship (Typ		19b Mailin	a Address (Stre	et and Number or F				n Code)
and 2 sho ealth and In 27 is ma	trau		DONNA MORRISION	DAUGHTER			LL ROAD				
s 1 and 3 tem 27	othe		20a. Method of Disposition	206.	Place of Dispos			Date	-	ation - City or T	
Pages nent of net: If it			1 ☐ Burial 2.XXX cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)		-	MATORY,		21/2004	CATO	ONSVILLE	E, MD
Deficiency of the Department of Heis Importent: If item	any injury o once.	Ì	21. Signature of Funeral Service Ligense	the state of the s						INERAL H	HOME, P.A.
1 225	a a	b d	M. Maul Cale	man	. 8	521 LOC	H RAVEN E	BLVD. TO	WSON,	MD 21	1286
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the dea e cause on each line.	ath. Do not ente	er the mode of d	ying, such as cardi	ac or respiratory	arrest,		Approximate Interval Between
Physic			Immediate Cause (Final disease or condition	LUNG	CANO	ER					mon Ths
/Med Exam	4.		resulting in death)	Due to (or as a conse							
xaiii		er	Sequentially list conditions, b	Due to (or as a sonta	cuerno effi-						
ted	nsit	nine	if any, teading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (5) 20 2 05/105	4401100 017.						
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rtifica ng ph	as the	a +	IF FEMALE:				27.07				
attendin	for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnar	псу		23	3d. Date of deliv Month	ery Day Year
the degr	hed fo	sicl	1 Yes 2 No	4□Pregnant at time of 9□ Unknown	death 5	Other (specify)				WOITH	Day Toal
that if	detached		Part II. Other significant conditions con	tributing to death but not re	sulting in the ur	derlving cause	uven in Part I.	23e. Did	tobacco us	e contribute to t	he cause of death?
signe signe	, 28	d by	COPD		3	,			Yes 2□		
Per wed	should	lete						24a. Wa:	san	24b Were autr	opsy findings available
he law requires to has been signe	page 2	Completed						auto	opsy ormed?	prior to co death?	impletion of cause of
→	lor, p	Be Co	25. Was case referred to medical				26. Place of De	1 Yes eath (Check only	one)	1 🗌 Yes	2 X No
- × ×	Ö	To B	examiner? 1 ☐ Yes 2 No	ospital: 1 Inpatient 2[⊒ ER/Outpatien	3□ DOA	Other: 4 Nursing			☐Other (Speci	fy)
ng Phy ter this			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. In	jury at fork?	28d. Describe			
or Attending after death. Director: Afte	he fu	atic	2 Accident investigation			M 1	☐ Yes 2 ☐ No				
or Att	in by t	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre cify)	et, factory, offic	θ		(Street and own, State)	Number or Run	al Route Number,
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After	pellij		29a. Certifier 1 Certifying Phys	ician: To the best of my kr	nowledge death	accurred at the	time date and cla	and die to the		and magnets	stated
Hos 24 ho	completely filled	Medical	(Check only one)	er: On the basis of examinand manger stated.	nation and/or inv	estigation, in my	opinion, death occ	curred at the time	date and p	and manner as s place, and due t	o the cause(s)
ro the	ошос	Me	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date	signed (Month,	Day, Year)
F > F	,		I for the	tong !	MD	D5:	3722		FA	n 19	2004
	X		30. Name and address of person who con		om 23a) (Type,		rey Pill:	ing, MD	- '		/
1	(1)		GOOD SAM	ARITAN	HOSPI	+1/	131LT1	MORE	/	MD	
)		31. Date filed (Month, Day, Year)	32. Registrar's Sign	110011	17,0		1-,		1/	

ORIGINAL

		•	For State Registrar	State of Maryland		artment of H tificate of L			iene () ()	0 1 7 6 9
			Decedent's Name (First, Middle, Last)					2. Date of Death	h Day Year	3. Time of Death
	Physicia /Medic		MATILDA ALICE	ROBINSON				Janue	79 arr. 44	43:41 AM
	Examin		4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town, or	Location of Death		4c. County of De	ath ai
7				rakitan		Ba	If Under 24 Hrs.	re		A
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year)	rthplace (State or Foreign country)
	Director		214-14-3689 Usual Residence of Decedent	87				1/3/19	17 14	ARYLAND
	land ow	1	10a. State 10b. County	10c. City	, Town or La	cation				10d. Inside City Limits
	Mary First	to	MD BALTIMOR	RE PA	RKVILL	Æ.				1 ☐ Yes XXNo
	n the	Directo	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What C	country?
	ours after death with the Marylan rai", or Items 23a or 28a-1 show Examiner must be notified at		8607 OAK ROAD			21234			USA	
	tems	Funeral	11. Marital Status	. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp In, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🕅 No	Specify:		Specify: W	HITE
215-0036	filed within 72 hours after death with the Maryland Hygione. the than 'natural', or Items 23a or 28a-f ehow the than 'natural', or Items or 23a or 28a-f ehow ant, the Macacal Examiner must be molified at		15. Decedent's Educa	ition	16a. Dece	dent's Usual Occupa	ation		16b. Kind of Busines	s/Industry
5	n na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of world)		OUNI HOME	
212	d with giene ar tha	mo.	7TH GRADE	30110g6 (1 401 01)	HOME	EMAKER			OWN HOME	
9	be filed within 72 ho ital Hygiene. Ind other than "natur event, the Michael	Be (17. Father's Name (First, Middle, Last)					ne (First, Middle, M	Maiden Surname)	
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Maryland 21	is 1 and 2 should of Health and Meritem 27 is marke other traumatic	11	19a. Informant's Name/Relationship (Typ) LINDA BARKER	e, Print) DAUGHTER		ng Address <i>(Street :</i> 7 OAK ROAI		ral Houte Number, IMORE, MD	. City or Town, State, 21234	Zip Code)
	1 and Health em 27 ther tr		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of	-		20c. Location - City of	r Town, State
ğ			1 ☐ Burial 2 X Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	moval from State	emetery, crei TRO CF	natory`or other plac REMATORY •	ind. 1/2	24/2004	CATONSVILL	E, MD
altimore,	permit. Page Department Importent: If any injury o		21. Signature Fureral Service Licenses							HOME, P.A.
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0	e deal	sicia	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of d 9☐Unknown	eath 5	Other (specify)		*******	i i i i i i i i i i i i i i i i i i i	buy roa
<u>م</u>	d by t	Phy	9 ☐ Unknown Part II. Other significant conditions cont	ributing to death but not res	ulting in the u	inderlying cause div	en in Part I	23e. Did tob	pacco use contribute	to the cause of death?
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a	ician: Th certificate rector, pag	e Co	25. Was case referred to medical				26. Place of Dea	th (Check only on		35 20 140
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joi	Attending I r death. ector: After by the funer	atio	1 Natural 5 Pending investigation				Yes 2 □ No			
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	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a, Certifier 1 Certifying Phys	cian: To the best of my kno	wlodeo de-	h accurred at the ti-	no data and place	and due to the	auca/s) and manner	as stated
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	->-0		1 Edmil	Dun	W	D	389	56 =	Januar	cy 20, 2004
	2		30. Name and address of person who con	npleted cause of death (Iter	п 23а) (Туре.	Print))	2 01.	la A	1,0
			Edward Seid	lex m)	5601	wich *	aven,	Dudn	nove, mi	any land
	St. Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	erufa	E.	,			

			110000	State of Marylan	d / Departm	nent of H	ealth and Me	ental Hyd	iene o o o	1 0:770
			For State Registrar	Otato of marytan	•	cate of E			eg. No.	14 017/0
			Decedent's Name (First, Middle, Las	t)	1			2. Date of Dea		ear 3. Time of Death
	Physicia /Medic		ARTURO	CASTILLE	> Koi	DRIG	UEZ	TAN.	19 20	04 2:45 M
	Examin		4a. Facility Name (If not institution, give	.1. 11		City, Town, or	Location of Death		4c. County of	Death
			JOSEPH RIC	CHIE HOSPI	-	DAUI Jnder 1 Year	MORE If Under 24 Hrs.	8. Date of Birth	NA	Birthologo (State of Foreign
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.		nths Days	Hours Min.	Month Day	3 1443	D. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent					/)// .0	
	yland how		10a. State 10b. County	1.	y, Town or Location					10d. Inside City Limits 1 ☑ ¥6s 2 ☐ No
	atter death with the Maryland or Itema 23a or 28a-f ehow rulnet rivest be nettified at	Funeral Director	W. VA N	R RA	INSON					
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	after death w or Itema 23a ruiner i uat t	eral	318 E. 311	AVE 12. Was Decedent Ever in U.	S. 13. Was I	254		cify Yes or No-	14. Race -	American Indian,
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5-0	n 72 hours "natural", edical Exp	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Decedent's (Give kind	Usual Occupa of work done d	ition furing most of working)	g	16b. Kind of Busi	ness/Industry
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<u>a</u>	2 T T	To Be	ANTENDIO C	0.STILLO			ALEJA	LNDAG	RODI	RIGUEZ
	s 1 and 2 should i Health and Men tem 27 le marke other traumatic		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing Ad	Idress (Street a	and Number or Rura	Route Numbe	City or Town, St	ate, Zip Code)
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PK P	ges 1 au it of Hea it filtern or othe		20a. Method of Disposition 1 Bunal 2 Cremation 3	1 0	Place of Disposition cemetery, cremator			22L	20c. Location - C	ity or Town, State
2 ts	nit. Page bartment o ortant: If injury or		'4 □Donation 3 □Other (Specify	1/1/	4/1/Ele	CKEM:	ac	04 1	HilB-	MD.
Bai	permit. Pages Department of Important: If It any injury or once.		21. Signature of Faneral Service Ligen	see Il a la la	22. Nat	me and Addres	S of Facility 28	29 HU	DSON 37	21224
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0	Dhusisian		Immediate Cause (Final	one cause on each line.	2					Interval Between Onset and Death
~ O	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq	ye Carwing =	- ((15) w 40	de lobel a	mur + T	8 healthing	(2)
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AS B	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of d		er (specify)			Month	n Day Year
J 109	at the	Phy	9 Unknown Part II. Other significant conditions of		uting in the under	vina cauco ano	on in Part I	23e Did to	hacco use contrib	ute to the cause of death?
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	requ been should	etec						24a. Was a	n 24h W	are autonsy findings available
T U R O C C C C C C C C C C C C C C C C C C	has l	Completed by						autop: perfor	med? de:	ere autopsy findings available or to completion of cause of ath?
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	ysicia s cert direct	To B	examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	Hospital: 1 Inpatient 2	ER/Outpatient 3	□ DOA Othe			ence 6 ☑Other	(Specify) Hos pier
AR	ig Ph ter th		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at 2	8d. Describe h	ow injury occurred	1
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	pital ours a leral [Ce	29a. Certifier 1 Certifying Ph	ysician: To the best of my kno	owiedne death occ	curred at the tim	ne, date and place, a	and due to the c	ause(s) and manr	ner as stated.
.p	To the Hospital or Attanding Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical		niner: On the basis of examina and manner stated.						
	To th Within To th comp	Me	29b. Signature and title of certifier	0		29c. License	number	4		(Month, Dey, Year)
		,	Dy B)	, אי, שי,			202175		1-19-	04
	3	1	30. Name and address of person who	completed cause of death (Iter	m 23a) (Type, Print	8821	+ Winand Illatour	s Boad		
	- 0				ature 🌶 🎿	Rano	lallatour	, MD	21173	
	Sta Regist		IAN 2.3 2004	32. Registrar's Signa	Contin	•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Agatha Ann Rider Jan 18 11:45 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ellicott City
If Under 1 Year | If Under 24 Hrs. Morningside Assisted Living Howard 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 👽 🗲 212-18-5499 Director 85 05/13/1919 $N \cdot Y$ Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Md Howard Ellicott City Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5330 Dorsey Hall Drive 21042 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Narried 1□Yes X□No Specify Specify:white à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry John's Hopkins Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien. Important: if them 27 is marked other thu any injury or other traumatic event. The Public Health Bio-chemist School of 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gottlieb Siegenthaler Agatha LeBlanc 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lou Chestnutt/POA 10001 Windstream Drive #1003, Columbia, cel Disposition (Name of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Balto/Wash. Crematory 01/23/2004 Laurel, Md. ash. Cremacoly

22. Name and Address of Facility Witzke Funeral Homes, Inc.

Columbia. Md. 21045 21. Signature of Funeral Service License 234 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** eum on 16 /Medical Examiner theimers Samentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed and physician a s the burial-t Due to (or as a consequence of) Physician/Medical as attending IF FEMALE: nse nse 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 DFetal death 3 Ectopic pregnancy į in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) the 1 Yes 2 No 9□ Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š cate has been sig, page 2 should b 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No Completed 24a. Was an autopsy performed?
1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) LIVING Hospital: 1 Inpatient 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: FACILIT 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai 29a. Certifier (Check only one)

P.0. Records, Division of Vital or Attending To the most after death.

Within 24 hours after death.

To the Funeral Director: Aft Hospital

Maryland 21215-0036

Baltimore,

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certified

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SM & RJ

11055

32. Registrar's Signature

29c. License number

20789

29d. Date signed (Month, Day, Year)

PATUXIENT PARKURY Columbia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** erON 200 anuaice /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 1-65 MORE If Under 24 Hrs. If Under 1 Year 8. (State or Foreign 6. Sex 7. Age (in yrs. last birthday) 5. Social Security Number Min. **Funeral** Days Months Hours 218-76-160 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County ir than "natural", or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Funeral Director more Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 212 Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Baltimore, Maryland 21215-0036 Specify: Specify: If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) t of Health and Mental Hygiane. If Item 27 is marked other than Elementary/Secondary (0-12) L 1 and 2 should be filed other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be reodore (Type, Print) moller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19a. Informant's Name/Relationship Nor andolph 20b. Place of Disposition (Name of corpetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition Pages 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) permit. Page Department o Important: If ò -10n Name and Address of Facility
Joseph L. Rus
2222 W. North 21. Signature of Funeral Service Lifensee Ave. 23a. Part | Et er the dise (e, or complication that caus shock, or heart failure) List only one cause on each line. Immediate Lause (Final disease or condition resulting in death)

Due to (or as a complete that the complete that Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Hours Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Tes 2 **X**(No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Was an autopsy performed?
Yes 2 No 24a. Was an has page 2 certificate 1 ☐ Yes Physician: 25. Was case referred to medical examiner?
1 □ Yes 2 □ No ector. Be 26. Place of Death (Check only one Other: 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 3 DOA D 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred in by the funeral 27. Manner of Death Certification: After Injury To the Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 January 16, 2004 MO

State Registrar 31. Date filed (Month, Day, Year) JAN 2 3 2004

ERIC SCHMIDT MD JOHNS HOPKINS HOSPIME GOO NORTH WOLFE STREET BALTIMURE 32. Registrar's Signatyre

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Donath.

MARYLAND

21287

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 01.

			,	Cer	tificate of	Death	Reg	2 U U 4	01//0
	Dhysisian	1. Decedent's Name (First, Middle, Last)	1) 1	2-7 0	1101		2. Date of Death Month	Day A Year	3. Time of Death
2	Physician /Medical	サイ スシン	H . S	ELR	UBA		anuary	22 2004	
j	Examiner	4a Fecility Name (If not institution, give s				4b. City, Town, or Loca BALTIMOR		4c. County of Death	h
		GOOD SAMARITAN NU		to an foliable stock	If Under 1 Year				
	Funeral Director	5. Sociel Security Number 6. Sex	M 2DTE	:. lest birthdey) Yrs.	Months Deys	Hours Min.	3. Date of Birth (Month, Day, Y 11/15/19	'eer) 9. Birti	hplace (State or Foreign untry)
3		184-16-4645 Usuel Residence of Decedent	82				11/15/19	ZI FEN	NSYLVANIA
	ylenc how	10a. State 10b. County		ity, Town or Loc					10d. Inside City Limits
	Marianian Ctor	MD BALTIMOR	E P.	ARKVILL.	E				1 □ Yes 2 🛣 No
	ath with the Maryler 23e or 28e-f show as be notified at rail Director	10e. Street end Number			10f. Zip Code		10g	g. Citizen of What Co	untry?
	ath w		ROAD		212	34		USA	
	r items 23 niner must Funeral	11. Marital Status	12. Was Decedent Ever in I Armed Forces?	J,S. 13. V	Vas Decedent of I Yes, specify Cub	Hispanic Origin? (Speci an, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Amer Black, White	
20	within 72 hours effer death with the Marylend ene. than "natural; or items 23s or 28s-f show ha Medical Examiner must be notified at sympleted by Funeral Director		1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	□Yes 2🛱 No	Specify:		Specify:	HITE
Maryland 21215-0020	2 hou	15. Decedent's Educ	cation		ent's Usual Occup		16	Sb. Kind of Business/I	
215	ed within 72 ho ygiene. For than "natura It, fre Medical Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give I life. D	kind of work done OO NOT use retire	during most of working d)	7		
7	giene giene gritha	12TH GRADE	College (1 401 01)	OPERA	TIONS MA	NAGER	Į,	<i>JZ</i>	
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Mar	0 m m e	19a. Informent's Name/Relationship (Ty)				and Number or Rurel I			
	s 1 and f Heelth tem 27 other ti	JANE ADAMS 20a. Method of Disposition	SISTER	Place of Dispos	SOUTH RI	VER DR. B	ALTIMORE Date 20	E, MD 212 c. Location - City or 1	
Baltimore,	0 0 = =	12 Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, crem	natory or other pla				
틆	permit. Peg Department Important: I any injury c	4 Donation 5 Other (Specify) 21. Signature of Funeral Service License			MEM. PAR			CLLENDALE,	
Ba	permit. Departm importal any inju	21. Signature of Funeral Service License				ess of Facility THE RAVEN BLV			1286
	-	Heath N	Hay						Tarana State Control
		23 Part1. Enter the disease, or compli- shock, or heart failure. List only on	e cause on each line.	ith. Do not ente	er the mode of ayı	ng, such as cardiac or i	respiratory arrest	1	Approximate Interval Between Onset and Death
	Physician /Medical	Immediate Cause (Final	FIET OF	50	0.1.0	1 51	Bron	91	2 Houths
100	Examiner	disease or condition resulting in deeth)	Metasta	or as a consequ	canc	er of	1x us		2100000
	<u> </u>		D00 10 (or as a consequ	derice or).	_		1	
	that the death certificate be executed ed by the attending physician and detached for use as the bunal-transit y Physician/Medical Examiner	Sequentially list conditions,	Due to (or as a consequ	uence of):				
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68760,	fficate be g physicia as the bur edical	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):			1	
×	ding page as								
Bo	attendi I for us								
P. 0.	at the death ce d by the attend etached for us Physician/	Part II. Other significant conditions con	tributing to death but not re	sulting in the un	derlying cause giv	ven in Part I.	100		to the cause of death?
	v requires that the death or been signed by the attend should be detached for us leted by Physician/						1 🗆 Yes	2□ No 3□ Pro	obably 4 Unknown
Vital Records,	The law requires the cate has been signed pege 2 should be completed by						24a. Was an a	autopsy 24b. V	Vere autopsy findings
00	w req beer shou						performe	d? a	vailable prior to completion of cause of death?
æ	The law ate has to pege 2 s						1 🗆 Yes	-A/I	☐Yes 2 No
ā	stcian: The law s certificate has t director, pege 2 s director, pege 2 s o Be Compli	25. Was case referred to medical				26. Place of Death (23010	2 763
\geq		examiner? 1 ☐ Yes 2 ☑No	ospital:	ER/Outpatient	3□ DOA Oth	or: e		ce 6 □Other (Spec	ify)
J Of	g Physicanthis heral di	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		d. Describe how		
Ö	Attending in death. Cotor: After by the fune fileation	1 Accident 5 Pending investigation	(Manua, 24) real,	injury		Yes 2□No			
Division	tal or Attending P is after death. al Director: After t led in by the funers Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	et, factory, office	28	f. Location (Stree City or Town, S	et and Number or Rui State)	ral Route Number,
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/	To the Hospital or Attending Phy within 24 hours after death. To the Fureral Director: After thi completely filled in by the funeral Medical Certification: T	29a. Certifier 1 Certifying Physic (Check only one) Medicai Examin	ician: To the best of my kno er: On the besis of examina and manner stated.	owledge, death ation and/or inve	occurred at the tirestigation, in my o	ne, date and plece, end pinion, death occurred	d due to the caus at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	within 2 To the comple	29b. Signature and title of certifier	and mailler stated.		29c. Licens	e number/ / 1	29d.	. Date signed (Month	, Dey, Year)
	- 5 - 0	Queat In	iperal	een	Di	30661	Ja	mierry 2	2004
	/1	30. Name and address of person who cor	npleted cause of death (Ite	m 23e) (Type. P	Print)		0 -		
	2		en Blud	1 Bo	ellime	re, Md	-212	139.	
	State	31. Dete filed (Month, Day, Year)	32 Registrer's Sign	ature 2	nall I				
	Registrar	JAN 2 3 200	4 1. 3660	of falls	Township Albert				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Betty Lou Stout Jan. 13 2004 19:16 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Memorial Hospital Havre de Grace Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 11/22/1921 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 ☐ M 2 🕱 F 234-32-3885 Yrs. West Virginia Director 82 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location : if item 27 is marked other than "natural", or Items 23s or 28s-1 ehow or other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Funeral Director 1X Yes 2 □ No MD Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 944 Chesapeake Drive USA 21078 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Bus Driver School land 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fil Iment of Health and Mental H tant: If item 27 is marked off Charles R. Harrison Mattie Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 is any injury or other trau once. Oliver Stout- Husband 944 Chesapeake Dr., Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co. 01/20/04 West Chester, PA 21. Signature of Funeral Service Licensee Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078 23a Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Box 68760 Physiclan/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 2 No certificate 1 ☐ Yes 2 ☐ No of Vital 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident Division 5 Pending investigation death. Il Director: A 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide hours after within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) Y 30. Name and address of person who completed cause of death (Item 23a) (Type, Brint)

State Registrar 1518000

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene O. O.

Baltimor Baltimor Baltimor ber Blvd. 1 2 Married Divorced 5. Decedent's Edury only highest grade dary (0-12) irst, Middle, Last) tzel ce/Relationship (Ty. Shannahar) sition Cremation 3 R	Apt. 3417 12. Was Decedent Eve Amed Forces? 1 Tyes 2 (M) by Year or Dates: Cation e completed) College (1-4or 5+) N/A Tel. Was Decedent Eve Amed Forces? 1 Tyes 2 (M) by Year or Dates: Cation e completed) College (1-4or 5+) N/A	n yrs. last birthdi Yrs Dc. City, Town or Balti or in U.S. 1	r Location more County 10f. Zip Code 2123	Location of Death If Under 24 Hrs. 8. Dat (Mc) Hours Min. Fell	te of Birth your, Yea D. 13,	year County of Deat P. 9. Bin Co 1920 MaI Sitizen of What Co USA 14. Race - Ame Black, Whit Specify: Wh	hplece (State or Foreign winty) 10d. Inside City Limits 1 Yes 2 X No nuntry?
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irst, Middle, Last) tzel ne/Relationship (Ty, Shannahar sition	N/A rpe, Print) n (Son)			/		Kind of Business/	Industry
tzel ne/Relationship <i>(Ty</i> Shannahar sition Cremation 3 □ R	n (Son)				Нс	usekeepi	ing-Own Home
Shannahar	n (Son)			18. Mother's Name (First, Mable Wei		en Sumame)	
Cremation 3 P				and Number or Rural Route rk Drive Bel			
☐ Other (Specify)	Removal from State	Place of Di cemetery, o Parkwo	isposition (Name of crematory or other place od Cemeter	Date 1-23-200		Location - City or timore,	
eral Service License	Charack		Lassann Fi 7401 Bela	ineral Home ir Rd. Baltin	more, M	d. 21236	
ditions, nediate years	Due to (or as a c	onsequence of):					Onset and Death
pregnant ponths?	23c. If yes, outcome of 1 ☐ Live birth 2 [4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of del Month	livery Day Year
ant conditions co	ntributing to death but r	not resulting in th	ne underlying cause give	en in Part I. 23			o the cause of death?
					ta. Was an autopsy performed? □ Yes 2 1 1	prior to death?	utopsy findings available completion of cause of
ed to medical	Hospital:	0EIE0/0	oth Oth	26. Place of Death (Chec		a []0# /0	
5 Pending	28a. Date of Injury (Month, Day Y	2 ☐ ER/Outpa 28b. Tim (ear) Inju	ne of 28c. Injury	y at 28d. D			спу)
6 Could not be determined	28e. Place of Injury building, etc. (· At home, farm 'Specify)	, street, factory, office				ıral Route Number,
	iner: On the basis of ex	camination and/o					
		7					
	investigation Could not be determined Certifying Phy	investigation Could not be determined 28e. Place of Injury building, etc. (Certifying Physician: To the best of a Medical Examiner: On the basis of examiner.	investigation Could not be determined 28e. Place of Injury · At home, farm building, etc. (Specify) Certifying Physician: To the best of my knowledge, can be defined building and manyler stated.	investigation Could not be determined 28e. Place of Injury: At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time medical Examiner: On the basis of examination and/or investigation, in my of and manner stated.	investigation Could not be determined 28e. Place of Injury : At home, farm, street, factory, office 28f. Local Could not be building, etc. (Specify) 28f. Local Could not be building, etc. (Spec	investigation Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street City or Town, State Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and manyler stated. 29c. License number 29d. I	investigation Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Ric City or Town, State) 28certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due and manner stated. 29c. License number 29d. Date signed (Mont

Swannahan, Virginia

			1 - For State Registrar		State	of Mary	land / Depa <i>Ce</i>	artmen <i>rtificat</i>	t of H e of L	lealth a	and M	lental Hy	gien	Sicre	004	ecuzioni (77(
			1. Decedent's Name (Fi	irst, Middle, La	st)							2. Date of De	eath			3. Time of	Death
	Physic /Medi		Betty		Ann		Sande	rs				- Month		ay こし	Year	3.54	P M
8	Exami		4a. Facility Name (If not	institution, giv	e street and no	ımber)			Town, or	Location	of Death		_	c. Coun	ty of Death	/	
			GOOD SA	MARI	MAT	Hos	HTIG	8	2 L-7	rima	ORE			1	AV		
	Funeral		5. Social Security Numb	er 6. S	eх		yrs. last birthday)	If Under		If Under		8. Date of Bi	rth V	-1	9. Birthp	lace (State or	Foreign
	Director		219-52-3018	1	□M 210 F	54	Yrs.	Months	Days	Hours	Min.	(Month, Da 2-21-		7	Md.	ntry)	
	D		Usual Residence of Dec														
	ahow	_		b. County		100	. City, Town or Lo	cation							1	0d. Inside City	y Limits
	Ba-fs	t c	Md.	NA			Baltir	nore								1X Yes	2 🗌 No
	er 28	Director	10e. Street and Number					10f. Zip	Code				10g. C	itizen of	What Cour	ntry?	
	23a	ai	824 N. Bro	adway					2120	5				F10.7			
	ems ems	Funerai	11. Marital Status		12. Was Dec	edent Ever	in U.S. 13.				gin? (Spe	ecify Yes or No Rican, etc.)	o-	14. Ra	ce - Americ	an Indian,	
9	or It	匠	1 Never Married	2☐ Married	1 ☐ Yes If Yes, G	2 XNo		_		Specify:	i, ruetto	nicali, etc.)			ack, White,	etc.	
g	irel',	dby	3 XWidowed 4 □	Divorced	Year or I			1 □ Yes 2	2 2 140	Specity.				Speci	^{ty:} Bla	.ck	
215-0036	within 72 hours after death with the Maryland ene. then "neture!", or Items 23a or 28a-f show the Madical Examiret must be notified at	Completed		Decedent's Ed	ducation ide <i>complet</i> ed)		16a. Dece	dent's Usua kind of wor	I Occupa	ation	t of worki	ina	16b. F	Cind of E	Business/Ind	dustry	
2	ithin Jen.	ld L	Elementary/Secondar		College (life.	DO NOT us	e retired,)		9					
2	filed w Hygier Sther th	ပ္ပ	12th grad				Cler	k					Bl	ue C	ross	Blue S	hiel
pu	m = 0 %	Be	17. Father's Name (First							18. Mothe	r's Name	(First, Middle	, Maidei	n Suma	me)		
yla	should be nd Menta marked Imatic ev	2	John		Н.		Thomas	5		Ann	ie		E	•	Воо	ker	
Maryland	2 sho and is my		19a. Informant's Name/	Relationship (Type, Print)		19b. Mailir	g Address	(Street a	ınd Numbe	er or Rura	I Route Numb	er, City	or Town	, State, Zip	Code)	
	요물 2 분		Annie Brow		Sister-			E. 26	oth S	Stree	t, Ba	altimor	e, I	١đ.	2121	8	
ore			20a. Method of Dispositi 1 D Burial 2 ☐ Cro		Domoval from		 b. Place of Dispo cemetery, crer 	sition /Nam	ne of		D	ate			- City or To	wn, State	
Ě	nit. Pages lartment of h ortent: If ite injury or of		4 Donation 5	Other (Specify	/)	State	Mt. Zic				1–26-	-04	Lar	ാടറ്റ	wne, l	Mď	
Baltimore,	e inject		21. Signatur at Funera	Service Lice	100	175-2		. Name and				22 - ROB 11					
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			23a. Part1. Enter the di	sease, or comp	olications that	caused the d						r respiratory a	rrest,	J. C	mvc.	Approximate	
1	Physician		shock, or heart fail Immediate Cause (Fina	/	/		-									Interval Between Onset and De	
1	/Medical		disease or condition resulting in death)	-			€ S∈ sequence of):	0515	<u> </u>							YAROU	5
	Examiner				~		10MIA										
		e	Sequentially list condition if any, leading to immed	ons, liate	0		sequence of):										
	nsit	듣	if any, leading to immed cause. Enter Underlying Cause (Disease or injury	~	-	· 0	MUIDIS	1		- \ _ 6	en.	COLL			-		
	and and all-tra	Examine	that initiated events resulting in death) Last				sequence of):		410	- / _ /	_	COLI	7 15	>			
68760,	icate be executed physician and s the burial-transit	ical E															
387		ਰ			. d												
	death certifi e attending ed for use as	Physician/Me	IF FEMALE:		23c. If yes, ou	tcome of pre	ananov.								-1-1/2-1		
Вох	atten for u	ian	23b. Was decedent preg in the past 12 mont		1 Live t	oirth 2 ☐ F	etal death 3 [Ectopic pre							ite of deliver	ry Day Ye	ar
o.	0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4⊟Pregr 9⊟Unkn	nant at time o own	ordeath 5∟	Other (spe	ecity)							,	
<u>α</u>	requires that the een signed by th hould be detache	유	Part II. Other significant	conditions	entributing to d	eath but not	consisting in the sur	dost in a se		- i- D-41		One Did to					
Vital Records,	ires t signe d be	þ	ACQUIRE													cause of dea	
o o	v requii been s should	teo	LOGOTAR	. 3.3 140	15/0 M	ORFF	ICIEMI	_ 7	396	HORG	2 ME		res 2	M NO	3 Propa	ıbly 4 ⊡Uni	known
ec	law as b	ompieted	CHROMIE	<u> </u>	VER	D'	SEASE					24a. Was autop		24b.	Were autop	sy findings av	allable
<u> </u>	ate Th	Con										perfo	rmed? 2 No		death?	2⊠ No	30 01
ita	Physicien: Th this certificate ral director, pag	Be (25. Was case referred to examiner?	medical						26. Place	of Death	(Check only o		_I			
>	9 0 F	은	1 ☐ Yes 2 🕱 No		Hospital: 1 💢	Inpatient 2	ER/Outpatient	3 DO	Other	r: 4 □ Nur	sing Hom	ne 5 🗆 Resid	ience	6 ∏Oth	er (Specify)		-
0	ding Phy h. After thi funeral c		27. Manner of Death	70	28a. Date	of Injury th, Day Year	28b. Time of	28	lc. Injury	at		8d. Describe h					
<u>ō</u>	Attending ir death. ector: After by the fune	atic	1 ⊠Natural 5 [2 ☐ Accident	☐ Pending investigation		in, Day roan) Injury	М		r es 2 □ N	10						
Division of	or Atten after deat Director: in by the	Certification;	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	289. Place	of Injury - A	t home, farm, stre	et, factory,	office		2	8f. Location (S	Street an	d Numb	er or Rural	Route Numbe	or,
Ö	el or A s after il Dire	ert	4 I Homiciae		Dullal	ng, etc. (Spe	эсігу)					City or Tow	m, State	")			
/	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the		29a. Certifier 15	Certifying Phy	/sician: To the	best of my i	knowledge, death	occurred a	t the time	e, date and	place, a	nd due to the o	cause(s)	and ma	nner as sta	ted.	
	He Fu	edicai	(Check only 2 1 1 one)	Medical Exam	iner: On the b	asis of exam ner stated.	ination and/or inv	estigation,	in my opi	nion, death	n occurre	d at the time, o	date and	place,	and due to	the cause(s)	-
	omp thir	Me	29b. Signature and title of	of certifier				29c.	License	number		- 2	29d. Dat	e signe	d (Month, D	ay, Year)	
	.)		■ RM	LANOS	TOT.	MN			RES	2 ^	20	i		_		, 200) .
	B	1	30. Name and address of				tem 22a) /Time 1							- 44	7 21	, 200	4
		Ì	_	r person who c	. \				EPE			TAME			010	2.22	/
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EDEM NYONATOR

		State of Maryland / Department of Maryland / D		lental Hygie	ne 2004 01777
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) James Milton Shimel Sr 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	2. Date of Death Month January 1	4c. County of Deeth
Funeral Director		1904 Chipper Drive 5. Social Security Number 6. Sex 1 M 2 F 68 Yrs.	Edgewood If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y) Dec 10,	Harford 9. Birthplace (State or Foreign Country) Pennsylvania
he Maryland 28a-f ahow	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo MD Harford Edgewood 10e. Street and Number 10e. Street and Number		100	10d. Inside City Limits 1 ☐ Yes 2√☐ No . Citizen of What Country?
s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Membal Hygiene. If Health and Membal Hygiene is the first of thems 23e or 28e-1 ahow other traumatic avent, the Movietic Examinarity and the notified at	by Funeral Dir	1904 Chipper Drive 11. Marital Status 1 □ Never Married 214 Married 1 □ Yes 2 2 2 No	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto		USA 14. Race - American Indian, Black, White, etc.
thin 72 hours a e. an "natural", or Mayleal Extra	Completed by	3 Wildowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+)	1 ☐ Yes 2 ☒ No Specify: dent's Usual Occupation kind of work done during most of works DO NOT use retired)	ing 16	Specify: white b. Kind of Business/Industry
should be filed with and Mental Hygiene, a marked other thai umatic avent, the	To Be Con	17. Father's Name (First, Middle, Last) John Clifford Shimel		e (First, Middle, Ma eabell Ma	
eges 1 and 2 sho nt of Health and it: If Item 27 Is ma r or other traums		Barbara Shimel/spouse 1904 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Dispo	Chipper Drive Edge sistion (Name of matory or other place)	ewood, MD	
permit. Peges 1 and Department of Heali Important: If Item 2 any injury or other once.			Name and Address of Facility tate Anatomy Board altimore, MD 2120	1	
Physician /Medical Examiner	j.	shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	veinoma haing. HX 7 COPD		
ite be executed sysician and he burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):	4470		
requires that the death certificate been signed by the attending phys should be detached for use as the	hysiclan/Medl		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
The law requires that the death the has been signed by the atter age 2 should be detached for u	0.	Part II. Other significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting the significant conditions contributing the significant conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions condi	nderlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
The lay ate has page 2	e Completed by	25. Was case referred to medical	26, Place of Deat	24a. Was an autopsy performe 1 Yes 2 Ch (Check only one)	
sid sid	ertification; To B	examiner? 1	d 28c. Injury at Work? M 1 Yes 2 No	me 5 Residence 28d. Describe how	injury occurred
To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: Atter th completely filled in by the funeral	edical Certifle	4 Homicide determined 209. Place of injury ski nome, family, ski building, etc. (Specify) 29a. Certifier (Check only 2 Medicel Exeminer: On the basis of examination and/or in	h occurred at the time, date and place,	City or Town, and due to the cau	se(s) and manner as stated.
To the To the Complete	Med	29b. Signature and title of certifier Dubbon C. M Lawe M.	29c. License number DOS7061 Print) CAMP BEUL BLUD	01/1	Date signed (Month, Dev. Year)
Sta Regist	ate	30. Name and address of person who completed cause of death (Item 23a) (Type, MOHAMMAD -	CAMP BELL BLUD	, BACTI	MORE, MD 21236

State of Maryland / Department of Health and Mental Hygiene 🤉 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Year William Brady Smith, Jr. JANUARY 9. 11:05AM 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F 69 Director 11, 1934 <u>413-54-1435</u> Dec. Tennessee Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Mode r than "natural", or Itema 23e or 28a-f ahov the Medical Exeminer must be notified at 1 Yes 25 No Director Maryland Harford Darlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1621 Castleton Road 21034 Funerai USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1∑Yes 2□No If Yes, Give Year or Dates:Vietnam 1 Never Married 2K Married Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: þ Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Pages 1 and 2 should be filed w thent of Health and Mental Hygie tant: If item 27 is marked other it jury or other traumatic avent, in Mechanic State Highway othar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Brady Smith, Sr. Lora Bell Perry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a If item 27 is or other train Arlene A. Smith / Wife 1621 Castleton Rd., Darlington, MD 21034 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Department o Important: If any injury or Harford Memorial Grdns 1-23-04 Aberdeen, Maryland permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 23a. Pert1. Enter the disease, or complications/that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, MD 21009 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** VENTRICULAR ARRHYTHMIA DAYS /Medical Due to (or as a consequence of): Examiner CARDIOGENIC SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-transit ACUTE MYOCARDIAL INFARCTION Box 68760, Physician/Medical CORONARY ARTERY DISEASE use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Munknown page 2 should Be Completed RESPIRATORY FAILURE peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has RENAL INSUFFICIENCY autopsy performed 1 Yes 2 No Division of Vital 1 Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a

To the Funeral C

completely filled i Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 01-20-04 D 30263 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERANCIS KHOO M.D. 7601 OSLER DRIVE TOWSON MARYLAND 21204 31. Date filed (Month, Day, Year) JAN 23 ZUU4 32. Registrar's Signature State market position do Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** W **TYLER JAMES** 04 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KIVERSI ORIGN If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) 4/7/1922 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) OHIO **Funeral** Days <u>¶</u>Д₩ 2□ F Months Hours Min 81 268-18-4359 Director Usual Residence of Decedent Demit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiane. Important: If item 27 le marked other than "naturel", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County r 28a-f show 10d. Inside City Limits XIX Yes 2 □ No Director MD HARFORD BELCAMP 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1208 MIST WOOD G 21017 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1XXX es 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2KNo Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) MINISTRY CHURCH 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANK TYLER MABEL MINNICH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1208 MIST WOOD G, BELCAMP, MD 21017 FAYE TYLER - WIFE Injury or other 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) RIVERSIDE CEMETERY UNK TROY OHIO or Dineral Service License 22. Name and Address of Facility FINK FUNERAL HOME, PA #MO1148 426 CRAIN HIGHWAY, S., GLEN BURNIE, MD 21061 KELLY GREGORY FINK 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** ntemosclerotic cardiovasular discuse Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner Hospital or Attending Physician: The law requires that the death certificeta be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last end Division of Vital Records, P.O. Box 68760, by Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? 1 🗆 Yes 20 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No edical Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After this in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ā within 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

				State of	maryland /		ificate of		и менан пу	Reg. No.	04	0 780
			1. Decedent's Name (First, Mic	ddle, Last)					2. Date of De			3. Time of Death
	Physici		James Dates, T	Towns In					Jan.	16 2	Year 2004	1 . OF 10 100
	/Medi		James Patsy T 4a Facility Name (If not institut	tion give street and num	her)			4b. City. Town.	or Location of Deat			1:05pm
-	Examir	ier							de Cuere			
			311 Northland 5. Social Security Number		7 8-0 // /0.04 /-	to the second	If Under 1 Year		de Grace		arford	
	Funeral Director		111-24-1379	6. Sex 1 M 2 □ F	7. Age (In yrs. last b. 71	Yrs.	Months Days		Irs. 8. Date of Bit (Month, Date of Bit (Month), Date	1932	9. Birthp Coun New	lace (State or Foreign try) York
	inyland show		Usual Residence of Decedent 10a. State 10b. Coun	nty	10c. City, Tov	vn or Loca	ation				11	0d. tnside City Limits
	W T	Director	MD Hart	ford	Havre	e de	Grace					1X Yes 2 □ No
	E 22	<u>le</u>	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	try?
	N M	=	311 Northland	s Court			21078			USA		
	Je at	era	11. Marital Status	12. Was Dece	dent Ever in U.S.	13. W			(Specify Yes or No erto Rican, etc.)		ce - Americ	an Indian,
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural; or flems 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral	1 ☐ Never Married 2 M	If Yes Give	2 □ No		Yes, specify Cub □ Yes 2) No		erto Rican, etc.)	Bla Specii	ck, White,	
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Maryland	should be ind Mental I	ို	James Patsy T	Torre, Sr.				Marga	ret A. D	Ambros	io	
<u>a</u>	2 sho and is me	- 1	19a. Informant's Name/Relatio	nship (Type, Print)	198	b. Mailing	Address (Street	and Number or	Rural Route Numb	er, City or Town	, State, Zip	Code)
	1 and 1 Health em 27	- 8	Patricia M. To	orre- Wife	31	11 No	orthland	s Ct.,	Havre de	Grace	, MD	21078
īe	of He		20a. Method of Disposition		20b. Place o	of Disposi	tion (Name of tory or other place	cel	Date	20c. Location	- City or To	wn, State
Ē	Pages nent of I nrt: If ite iry or o		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	n 3 □Removal from S /Snecify)	itate		l Cemete		1/19/04	Havre	de Cr	ace MD
Baltimore,	permit. Page Depertment of Important: If any injury or once.	- 1	21. Signature of Funeral Service		Mige							acc, wib
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1			3a. Part 1. Enter the disease, shock, or heart failure. Li	or complications that ca ist onty one cause on ea	used the death. Do ich line.	not enter	the mode of dyir	ng, such as card	liac or respiratory a	rrest,	i	Approximate Interval Between
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	/Medical Examiner		Immediate Cause (Final disease or condition	· MAr	VC:REAT	70	CAN	CER			1	MONTHS
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of Vital	Physician; The this certificate ral diractor, pag	Be	25. Was case referred to medic examiner?					26. Place of D	eath (Check only o	ne)		
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0	g Ph er thi		27. Manner of Death	28a. Date of		Time of	28c. Injur Wor	y at	28d. Describe I	now injury occur	red	
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Division	Attending ir death. actor: After by the fune	<u>ë</u>	3 ☐ Suicide 6 ☐ Could	rmined 286. Place C	of Injury - At home, fa	ırm, stree	t, factory, office		28f. Location (S	Street and Numb	er or Rural	Route Number,
Ö	i or Attend a aftar death i Director: /	Certification:	4 ☐ Homicide	building	g, etc. (Specify)				City or Tov	vn, State)		
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100	To the Hospital or Attending Ph within 24 hours aftar death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Modice one)	al Examiner: On the bas and manne	is of examination an	d/or inves	stigation, in my o	pinion, death oc	curred at the time,	date and place,	and due to	the cause(s)
`	vithin 24	Z	29b. Signature and title dicertif			~	29c. Licens	e number		29d. Date signe	d (Month, E	Day, Year)
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	19		30. Name and address of person	in who completed cayse	of death (Item 23a)	(Type, Pr	SRA CI	TITE DO	LUTHER	All IE	MOS	21093
		a l	31. Date filed (Month, Day, Yea	コートン・シ	gistrar's Sanature	1/1	~ 11V) 30	1115 20	1 2011101	MILES	シュ	1010
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	/Medic		4a. Facility Name (If not institution, give			113111	4h City Town	or Location of De		4c. County of De	
	Examir	ier							411	40. County of De	
	F		Genesis Eldercare 5. Social Security Number 6. Se			st birthday)	# Balt	imore	rs. 8. Date of Birt	N/	A Sirthplace (State or Foreign
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	yland		10a. State 10b. County		10c. City,	Town or Lo	cation				10d. Inside City Limits
	Mar Mar	ţō	Maryland N/A			Balt:	imore				1 ØYes 2 □ No
	7.28g	Director	10e. Street and Number			2410	10f. Zip Code			10g. Citizen of What	Country?
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	death with the Maryland ma 23a or 28a-f show rmail be notified at	Funeral	11. Maritaf Status	12. Was Decedent E	ver in U.S	. 13. \	Vas Decedent of		(Specify Yes or No- erto Rican, etc.)		nerican Indian,
Ω	or Ite	Ē	1 Never Married 2 Married	Armed Forces?	lo				erto Rican, etc.)	Black, Wi	nite, etc.
3	ors a	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:			☐ Yes 2 No	Specify:		Specify:	White
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ğ	othe	a	17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Middle,	Maiden Sumame)	
land	fentai rked o	To B	James Brooks					Cather	ine J	ohnson	
a S	s 1 and 2 should be filed within 72 hours after death with the Manylan I Health and Mental Hygiene. item 27 is marked other than "natural", or Itema 23a or 28a-1 show other traumatic event. The Medical Examiner must be notified at		19a. Informant's Name/Relationship (T	ype, Print)		19b. Mailin	g Address (Stree			r, City or Town, State	, Zip Code)
<u></u> 0	and 2 salth a n 27 ls		Teresa A. Pridgeon	(Daughte	er)	163	37 Re1t	Street	Raltimore	. Maryland	1 21230
ā,	S 1 a f Hez ftam othe		20a. Method of Disposition		20b. Pla	ce of Dispos	sition (Name of		Date	20c. Location - City	
9	Pages nent of int: If it		1 Burial 2 Cremation 3 □I 4 □Donation 5 □Other (Specify)			Page 1	atory`or other piz	tery 01-	24-04	Baltimore	Maryland
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			23a ant 1 Enter the disease or comp	lications that caused	the death	Do not ente	30 East	Fort Av	enue, Bal	timore, Ma	aryland Approximate
			23a. ert1. Enter the disease, or comp shock, or heart failure. List only o	ne cause on each lin	e.	DO NOT BITTE	ar the mode or dy	ing, such as cardi	ac or respiratory arr	est,	Interval Between Onset and Death
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X Q Q	death certifi e attending ed for use as	an/I	23b. Was decedent pregnant	23c. ff yes, outcome of 1 □ Live birth			Ectopic pregnanc	:v		23d. Date of d	,
	dea od fo	slci	in the past 12 months?	4☐Pregnant at t			Other (specify) _	,		Month	Day Year
5	w requires that the death certifice been signed by the attending I should be detached for use as	Physician/M	9 Unknown								
'n	s the	by F	Part II. Other significant conditions co	ntributing to death bu	t not result	ing in the un	derlying cause gr	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ë	quire an sig uld t		(0/0)						1 🗆 Y	es 2□No 3 <mark>5</mark> ,F	Probably 4 Unknown
Records	s bee	Completed							24a. Was a	in 24b. Were a	autopsy findings available
T C	sician: The law certificate has b lirector, page 2 si	E							autops perfor	maed? death?	autopsy findings available completion of cause of
N II a		Ö	25. Was case referred to medical					OC Disease of D	-	2No 1□Ye	s 2 No
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UNISION	deal deal ctor: y the	fica	3 Suicide 6 □ Could not be	28e. Pface of Inju	rv - At hom	e farm stre	4		28f Location (St	treet and Number or F	Pural Pouta Number
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_	To the Mospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Phy	sician: To the best o	f my knowl	edne doot	Occurred at the t	me data and al-	no and due to the	ause(s) and manner a	o stated
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	o the	Me	29b. Signature and title of certifier				29c. Licens	se number	2	9d. Date signed (Mor	nth. Dav. Yearl
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			30. Name and address of person who co		ath (Item 2	:Ja) (Type, f	rint)	Lune.	0	1	
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 1, Taylor Month **Physician** Jacqueline 2:33 P M Junuary 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Center Bayview Medical Baltimore Johns Hopkins N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) 5/2/50 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days 1 □ M 200 F 219-52-3079 53 MARYLAND Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r than "naturel", or items 23s or 28e-f ehow the Medical Examiner must be notified at 1⊠Yes 2 No **Funeral Director** N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 602 S. BELNORD AVE. 21224 USA death 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No 0 Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 ☑ No Specify: ρ 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DANMAR Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If Item 27 ie marked other it any injury or other traumatic event, Itta ance. 0 COMPUTER ANALYST MANUFACTURING 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) DOLORES LOWE HENRY RUSSELL BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACQUELINE A. TAYLOR S. MONTFORD AVE. BALTIMORE, MD. 21224 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State BAYVIEW CREMATORY 1/25/04 BALTIMORE, MD. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses KACZOROWSKICHTUNERAL HOME P.A. 1201 DUNDALK AVE. BALTIMORE, MD. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. يم Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis Physician 3 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 4 days Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of Leads or in jury that initiated events Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 4 Unknown Circhosis 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform Hospital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Pending Injury after death.

Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) January 21, 2004 MD RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carnegie 568, Johns Hopkins Hospital 600 N. Wolfe Steet, Baltimore, MD 21287 Johnston, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MN 2 3 2004

			1 - For State Registrar	State of Ma	ryland		rtment of F		Mental Hy	/giene Reg. No	CULL	01783
	Physici	an	1. Decedent's Name (First, Middle, La	ist)		ml			2. Date of D Month	eath Da	y Year	3. Time of Death
1	/Medic	al	Jeraldine	a street and number)		Thoma		r Logation of Dogs	1	18	2004	2:p M
j.	Examin	er	4a. Facility Name (If not institution, gir				Balti	r Location of Deat	п	40	. County of Death	,
	Funeral		Lorien Frankfor 5. Social Security Number 6.		(In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs		rth		place (State or Foreign
	Director		231-56-6723	¹⁄æ™ ²□F 58	3	Yrs.	Months Days	Hours Min.	10-27	45–45		a.
	pu 🔭		Usual Residence of Decedent 10a, State 10b, County		10c City	Town or Lo	nation				1.	0d. Inside City Limits
	Aaryla F sho	ō	Md. NA			Baltimo					'	1 ☑ Yes 2 ☐ No
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	deatl	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S		Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S	pecify Yes or N		14. Race - Americ Black, White,	
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315-0036	d within 72 hours after death with the Marylan jone. I than "natural", or Items 23a or 28a-f ahow Tha Medical Examiner man be notified a	ed b	3 ☐ Widowed 4 🏋 Divorced 15. Decedent's E	Year or Dates:		16a Deced	ent's Usual Occup	ation		16b K	ind of Business/In	
Ç	within 72 ene. than "na	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed)		(Give life. L	kind of work done	during most of wo.	rking	100.1	3110 01 003111633/111	odstry
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<u> </u>	2 should be fited and Mental Hygid is marked other aumatic event, II	Be	17. Father's Name (First, Middle, Last	•				18. Mother's Nar	me (First, Middle	, Maider		
yland	Ment Ment arked	T _o	George		omas			Edna			Thomas	
Ma	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship									^{Code)} 20011
	1 and Healt em 2		Diane Jordan 20a. Method of Disposition	Niece	20b. Pla		Sition (Name of natory or other place		Date		hington, ocation · City or To	
D D	ages ant of it: If it		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Speci		1	_{тетегу, степ} Zion		1-24	L-04		nsdowne,	
galtimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic es ance.	1	21. Signature of Funeral Service Le	2 0	W 1		Name and Addre			_		21202
ă	Depared Important any ire		Jeler C			1	March F.H	I. East			e, Md. 2 North Ave	
			23a. Part1. Enter the disease, or on shock, or heart failure. List only	lications that caused to	the death.	Do not ente	er the mode of dyin	g, such as cardia	or respiratory	arrest,		Approximate Interval Between
	Physician		tmmediate Cause (Final disease or condition	Acole	n-00	undia	1 In	Gretion			1	Onset and Death
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٥	e as t	Med	IF FEMALE:									
X Q Q	death certiff e attending d for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o	Fetat	death 3	Ectopic pregnancy				23d. Date of delive Month	nry Day Year
j	he de / the a	ysic	1 □ Yes 2 No 9 □ Unknown	4□Pregnant at t 9□Unknown	ime oi dea	atn 5 🗆	Other (specify)					
Ţ.	w requires that the death certif been signed by the attending should be detached for use a:	ьу Р	Part II. Other significant conditions	contributing to death but	not result	ting in the un	derlying cause giv	en in Part I.	23e. Did	tobacco i	use contribute to th	ne cause of death?
ecords,	quires n sign								1 🗆	Yes 💈	⊠ No 3□Prob	ably 4 Unknown
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VIII	ysician: This certificate	Be (25. Was case referred to medical examiner?					26. Place of Dea	ath (Check only	one)		
0	Ø .⊴ ₽	2	1 Yes 2 No	Hospital: 1 ☐ Inpatien 28a. Date of Injury		R/Outpatient		a vursing r			6 □Other (Specify	1)
	ding h. After fune	tion	27. Manner of Death Natural 5 Pending 2 Accident Investigation	(Month, Day	Year)	28b. Time of tnjury	28c. Injun Worl	/at k? Yes 2 □No	28d. Describe	now injui	ry occurred	
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É	2 9 E	Certification;	4 Homicide	building, etc.	(Specify)				City or To	wn, State)	
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the		29a. Certifier Certifying P	hysician: To the best of miner: On the basis of	my know	ledge, death	occurred at the tin	ne, date and place	, and due to the	cause(s)	and manner as st	ated.
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)	To Voit		29b. Signature and title of certifie	//		\bigcirc	29c. Licensi	3386		Zed. Da	te signed (Month, i	vay, reaf)
	y		30. Name and address of person who	completed cause of to	ath (ltom (23a\ (Tunn 1					1/23/04	
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	Physicia /Medic		Robert Lou	iis	Thomps	son,	Sr.					Januar		ay 9,20	Year 004	10:50	O AM
	Examin		4a Facility Name (If not institu	tion, give	e street end nu	umber)				4	4b. City, Town, or I	Location of Deet		c. County			
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	pu *		Usual Residence of Decedent 10a. State 10b. Cour	ntv			10c. City.	Town or Lo	cation						10	d. Inside City	/ Limits
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	the 128s-	Director	Maryland Harf 10e. Street and Number	.ora			F.	lavre (10f. Zip (10g. C	itizen of W	/hat Count	ry?	
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	daati	Funeral	11. Marital Status		12. Was Dec	cedent Ev	er in U,S	3. 13. V	Vas Decede		lispanic Origin? (S an, Mexican, Puert	pecify Yes or No) -		- America		
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<u>~</u>	perm Depa Impo any ii		21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral 1317 Cokesbury 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as of shock, or heart failure. List only one cause on each line.								sbury Roa	d. Abin	ador	n, MD			
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X	ithin 2 o the	Med	one) 29b. Signature and title of certi	fier	and mar	nner state	· .		29c.	Licens	e number		29d. D	ate signed	(Month, D	ay, Year)	
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	\sim		30. Name an address of person	on the	completed cau	ise of dea	th (Item :	23a) (Type. I	Print)	u ;	, v = ad		7/11	10 41 /1 /	-10	1 20	7
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			State of Maryland / Department of Health and Certificate of Death		lene 200	4 01785
	Dhariet		Decedent's Name (First, Middle, Lest)	2. Date of Dea Month	th Day Year	3. Time of Death
4	Physicia /Medic		Charles Wesley Tyson	Januar	y 18, 2004	
)	Examin		the footing views (i	Location of Death	4c. County of Dee	
	*		16 Huntington Place Bel Air 5 Social Security Number 6 Sex 7 Age (In vrs. last birthdey) If Under 1 Year If Under 24 Hr		Harfo	
	Funeral Director		5. Social Security Number 219-16-4397 6. Sex 129-16-4397 7. Age (In yrs. last birthdey) 7. Ag			thplace <i>(Stat</i> e or Foreign ountry) ryland
	dend		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Many	to	Maryland Harford Bel Air			1 ☐ Yes 2 € No
	or 284	lrec	10e. Street and Number 10f. Zip Code		log. Citizen of What C	
	23a	raic	16 Huntington Place 21015		USA	
020	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylend Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at page.	by Funeral Director	11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Never Married 2 Married 1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No 1 ☐ Y	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi Specify: W.	te, etc.
5-0	72 hc	eted	15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of we life. DO NOT use retired)	orking	16b. Kind of Business	s/Industry
121	within he.	d d	Elementary/Secondary (0-12) 12 College (1-4or 5+) Estimator		Fabricati	on
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an	id be ental ked o	To Be Completed by		Elizabe	th Walker	
Mary	id 2 shou Ith and M ?7 is mar! traumat	-	19a. Informant's Name/Relationship (Type, Print) Carrie Lee Tyson/Wife 19b. Mailing Address (Street and Number or Foundation Place,			Zip Code)
Baltimore, Maryland 21215-0020	eges 1 ar nt of Hea :: If Item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Christian Church Cem.	Date 1-2/1-0/4	20c. Location - City of	
Ħ	artme ortani injury	Î	21. Signature of Auneral Service Licensee 22. Name and Address of Facility		2. 2.	
ä	Departiment in portion in portion in price.		McComas Funeral H			1.000
			23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	ac or respiratory ar	gaon, MD 2. rest,	Approximate Interval Between
1	Physician		Shock, of real training. List only one cause of each line.	/		Onset and Death
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ć	ificate be executed g physician and es the bunal-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of):			
68760,	ysicia	cal	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
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Division of Vital Records, P.O. Box	Attanding Physician: The lew requires that the deeth cert restr. r death. sctor: After this certificate has been signed by the ettendin by the funeral director, page 2 should be detached for use	Completed by Physician/M		24a. Was a		Were autopsy findings available prior to completion of cause
3ec	has b	mple				of death?
a	n: The licate n, pag	ပ္	OF Was and of the district of	1		1 ☐ Yes 2 ☐ No
₹	siciar certif irecto	To Be	examiner?	eath (Check only or	ne) ence 6 □Other (Spe	noife i
0	Phy ar this eral o	E	27. Manner of Deeth 28a. Date of Injury 28b. Time of 28c. Injury at		ow injury occurred	scriyy
Ö	ath. r: Atte	atio	2 Accident investigation M 1 Yes 2 No			
Divis	To the Mospital or Attending Physician: The lew within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	treet and Number or F n, State)	lural Route Number,
	tospit t hour unera	cal (29a. Certifier (Check only Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date end place 12 Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date end place 12 Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date end place 13 14 15 15 15 15 15 15 15	e, and due to the c	ause(s) and manner a	s stated. e to the cause(s)
	the the the E	Medical	and manner stated.		29d. Date signed (Mon	
				j i		
	3	1	20 Name and address of passes who completed around death (Name 22) (Time Print)	O .	./17/04	
	1	ļ	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sendel R. Leward, up 821 N. EUA	rw \$40	- Bulkha	21201
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature		7 77	1
	Registr	21	IAN Z 3 ZUU4			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY 17, **Physician** THOMAS GAYLE WHITE 2004 7:45 P M /Medical 4a. Fecifity Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GLEN BURNIE 1080 CAYER DRIVE ANNE ARUNDEL ff Under 1 Year | ff Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/25/1940 5. Social Security Number 7. Age (In vrs. last birthday) Birthpface (State or Foreign Country) **Funeral** Months Days Hours Min. XXM 2□F 63 219-26-6053 Director Virgiñia Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show er than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2XXNo Directo GLEN BURNIE ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1080 CAYER DRIVE 21061 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. antie if Itam 27 is marked other than "natural", or ite 1 Never Married 2 Married 1 ☐ Yes XX☐ No Specify Specify: WHITE 3 □ Widowed XX Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coflege (1-4or 5+) 11 LABORER GLOBE BLINDS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRED E. WHITE CHARLOTTE LATTAU 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ADELAIDE HASLUP 1080 CAYER DRIVE, GLEN BURNIE, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages I Department of H Important: If Its any injury or ot 1 X Kurial 2 □ Cremation 3 □ Removal from State 1/21/2004 ¹ 4 □Donation 5 □Other (Specify) CEDAR HILL CEMETERY BALTIMORE, MD 21. Signature or Funeral Service Licenses 22. Name and Address of Facility FINK FUNERAL HOME, PA GREGORA 426 CRAIN HIGHWAY, S, GLEN BURNIE, MD 21061 KHLLY FINK #M01148 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2 lil /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetef death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown à Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1□ Yes XX□ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home XX Residence 6 Other (Specify) Hospital: P 1 ☐ Yes ŽXNo 1 🗀 Inpatient 2 ER/Outpatient 3 DOA this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Alter 5 Pending investigation Infury 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

200 Registrar Signature

04

31. Date filed (Month, Day,

DI-		1. Decedent's Name (First, Middle, La.	st)		2. Date of Death	Day	3. Time of Death
Physici /Medic		GLENN	HAROLD	WAGNER	January	$13^{\text{Day}}, 2004^{\text{eer}}$	12:55 A
Examin		4a. Fecility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Death	
		Western Correction	onal Institution	Cumberland		Allegan	ïΥ
Funeral Director			ex 7. Age (In yrs. last birthda XM 2□ F 35 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, 1)	9. Birth <i>Cou</i>	place (State or Foreig intry)
*	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
faho	ō						1 ☐ Yes 2 ☐ No
23a or 28a-f show ust be notified at	Director	10e. Street and Number		10f. Zip Code	100	. Citizen of What Cou	intry?
ns 23,	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. 1	3. Was Decedent of Hispanic Origin? /Sp.	acity Vac or No.	14. Race - Ameri	ean Indian
r ten	ᆵ	1 □XNever Married 2 □ Married	Armed Forces? 1 ☐ Yes ② X No	 Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerto 	Rican, etc.)	Black, White,	
P. C. Or	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes XX No Specify:		Specify: WH	ITE
'natural', adical Ex	Completed	15. Decedent's Ed (Specify only highest gra	ucation 16a. De (Gi	cedent's Usual Occupation ive kind of work done during most of work a. DO NOT use retired)	ing 16	b. Kind of Business/Ir	ndustry
then	dw	Elementary/Secondary (0-12)	College (1-40f 5+)	AUTO MECHANIC		AUTO REPAI	D
I Hygiene. other then	CO	17. Father's Name (First, Middle, Last)			(First, Middle, Ma		N.
ked c	To B	KEITH WAGNER			DENNING	ioon oumano,	
arment of Health and Mental Hygiene. ortant: if item 27 is marked other than injury or other traumatic svent, the M.	-	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ailing Address (Street and Number or Rura	al Route Number, C	ity or Town, State, Zi	o Code)
aith an 127 is ar trau		NANCY WAGNER - N		5 McNEIL ROAD, ROCK			
Department or Health Important: If item 27 any injury or other treates.	1	20a. Method of Disposition	20b. Place of Dis	sposition (Name of rematory or other place)	ate 20	c. Location - City or To	own, State
ant: H		1 ☐ Burial 2\(\overline{2}\)Cremation 3 ☐ \(^1\) 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	W CREMATORY 1/17/	2004	BALTIMORE,	MD
Importa		21. Signature of Funeral Service Lice	59.	22. Name and Address of Facility FIN	K FUNERAL	L HOME, PA	
E # 9		ĸĿĹĹŶĞŘĬĠŌŖŊ	INK #M01148	426 CRAIN HWY., S,	GLEN BUI	RNIE, MD 2	1061
ysician Medical aminer He prival-transit	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. NARCOTTC INIOXICA* Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of):	enter the mode of dying, such as cardiac c			Interval Between Onset and Death
ysicia ie bu	edical	IS SERVALE.	d				
led by the attending ph detached for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		B Ectopic pregnancy C Other (specify)		23d. Date of delive Month	ery Day Year
5 2	۾	Part II. Other significant conditions of	ontributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to th 2 □ No 3 □ Prob	/
s been 2 shouk	Completed				24a. Was an	24b. Were auto	psy findings available
rector, page 2 s	EO				autopsy performed 1 Yes 2	1? death?	mpletion of cause of 2□ No
director.	Be	25. Was case referred to medical examiner?		26. Place of Death		163	2010
. <u>₩</u> •	2	1 XYes 2 □ No	Hospital: 1 Inpatient 2 ER/Outpati	ent 3 DOA Other: 4 Nursing Hon	ne 5 🗆 Residenc	e 6X10ther (Specify	at scene
tor: After th the funeral	on:	27. Manner of Death 1 □Natural 5 □ Pending	128a. Date of Injury 28b. Time fourtulury	Work?	8d. Describe how	njury occurred	
the fu	cati	2 Accident investigation 3 Suicide 6XXCould not be	1/13/04 12;0		UNKNOWN		
al Director: ed in by the	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify) FOUND IN CELL	street, factory, office	18f. Location (Street IESTERN CORS CUMBERLA	t and Number or Flura LEETIONAL INS AND MD	l Route Number, STITUIE
	Medical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exam	vsician: To the best of my knowledge, dea iner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, a investigation, in my opinion, death occurre	nd due to the caus	e/e) and mannor as et	ated. the cause(s)
To th	₹	29b. Signature and title of certifier	000	29c. License number	29d.	Date signed (Month, I	Day, Year)
		Matri le	mich-toller n	O.C.M.E.	Ja	nuary 14,	2004
	-		ompleted eause of death (Item 23a) (Type			<u> </u>	-

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene?

					iai yiai ic		tificate c			ornar riy	Reg. No.			0.0
			1. Decedent's Name (First, Mid	idle, Last)						2. Date of De Month		Voca	3. Time of	Death
	Physici /Medio		Evelyn M	largaret	Wa-	HS.				DI	17	O4	2:00	PH
7	Examir		4a. Facility Name (If not instituti	tion, give treet and number) 11					ation of Death				
			Maryland	Masonia	- H1	one		1	ysvill		Balti			
	Funeral Director		5. Social Security Number 212 03 6433		ge (In yrs. la 38	est birthday) Yrs.	Months Day		Min.	8. Date of Bir (Month, Da June 22	1915	9. Birthp <i>Cour</i> Baltin	place (State of ntry) DOITE, Mary	r Foreign yland
	and .		Usual Residence of Decedent 10a. State 10b. Count	ity	10c. City,	, Town or Loc	ation					1	I0d. Inside Cit	v Limits
	Menyl f sho	ō	Maryland Baltim	ore	Baltir	more Cou	intv						1 ☐ Yes	•
	28e	rect	10e. Street and Number				10f. Zip Code	Ð			10g. Citizen of	What Cour	ntry?	
	3a o	Funeral Director	2002 Wintergreen F	Place			21237				USA			
	death	ner	11. Marital Status	12. Was Decedent	Ever in U,S	S. 13. W	/as Decedent of Yes, specify C	of Hispanic Ori	igin? (Spec	cify Yes or No	- 14. Rac	ce - Americ		
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "netural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Never Married 2 ☐ Ma	If Yes Give	No		Tes, specify C ☐ Yes 24021 N			ilcari, etc.)	Specif	ck, White, ^{5y:} Wh	eic. nite	
5-0	72 hc	eted	15. Decede	ent's Education hest grade completed)		16a. Decede	ent's Usual Occ	cupation	st of workin	a	16b. Kind of B	usiness/In	dustry	
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2	led w lygier ner th	Col				Secreta	ry	40.84-11	- 1- 11	/m:	Banking		гy	
and	ntal F	To Be	17. Father's Name (First, Middle Clarence E McJilt	· · · · · · · · · · · · · · · · · · ·				1		eth Rupp	<i>Maiden S</i> uman ert	nej		
2	hould d Me merk metic	To	19a. Informant's Name/Relation	'0"	ļ	10h Mailine	Address /Str	IIII.		77.00	er, City or Town	State Zir	Codel	
Z	d 2 s Ith an 7 is		Karen A Watts								aryland 2		, 0000	
ē,	s 1 ar f Hea tem 2		20a. Method of Disposition		20b. Pla	ace of Dispos	ition (Name of atory or other p	2000)		Date	20c. Location	- City or To	own, State	
Ë	Page ent o nt: If I		XX Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Cem. Jan		2004		Baltimore	.Marvl	and	
alti	mit. partm portal / inju		21. Signature of Funeral Service			22.	Name and Ad	dress of Facili	ity			, ,		
Ω	Dermi Depa Impo any ir		May come	an Chance	V.	740	sahn Fun 11 Belair	era⊥ Hon Road Ba	me inc altimom	re. Marv	land 2123	6		
			23a. Part1. Enter the disease, shock, or heart failure. Li										Approximate Interval Betw) yeen
}	Physician			6 -									Onset and D	eath
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. and St	age	Dener	rteai					i		
		ē	resulting in deathy	1	Due to (or	as a consequ	ence of): OS Cule	7.	1					
	uted f insit	Examiner		6. AT NO			9	n DIJ	معدي					
oʻ.	eath certificate be executed ettending physician and I for use as the buriel-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1	Due to (or	as a consequ	erice ory.							
68760,	ste be nysiciá he bu	edical	Cause (Disease or injury that initiated events resulting in death) Last	C	Due to (or a	as a consequ	ence of):							
39	entifice ing ph e as t	2	rosulting in doutry Last	L										
Box	ath ce ttendi or use	lan/		d .						ne:				
o O	the e	ysic	Part II. Other algnificant condit	tions contributing to death t	out not result	ting in the un	derlying cause	given in Part I	l.	23b. Did 1	obacco use co	ntribute to	the cause o	f death?
P. 0.	The law requires that the death ate has been signed by the etter page 2 should be deteched for I	Completed by Physician/	Hypertensin	, arthutis,	Depe	ssin	, Oste	oporesi	in	1 🗆 '	Yes 2□ No	3 ☐ Prot	bably 412 l	Jnknown
Division of Vital Records,	sign Id be	d b	11	/		,				24a Was	an autopsy	24b. W	ere autopsy fi	ndings
Ö	v request	lete								perfo	rmed?	cor	ailable prior to mpletion of ca death?	
æ	ne lav e has age 2	μc								101	es 2 No		ueaun: ⊒Yes 2⊠⊒I	No
ā	ifficate	Be C	25. Was case referred to medic	cal				26 Place	e of Death	(Check only o			1165 4/241	10
\geq	Physician: this certific ral director,	T 0	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpati	ent 2□E	R/Outpatient	3□ DOA	Au			lence 6 □Oth	er (Specif	v)	
0	ig Ph ter thi	ü	27. Manner of Death 1 ⊠Natural 5 □ Pend	28a. Date of Inju	ar Year)	28b. Time of Injury	28c. Ir				now injury occur			
ō	Attending or death. ector: After by the fune	atic	2 ☐ Accident inves	stigation				☐Yes 2☐	No					
<u>≅</u>	or Att after de Directe	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined Zoe. Place of III	jury - At hon tc. <i>(Specify)</i>	ne, farm, stre	et, factory, offic	Э	28	Bf. Location (5 City or Tox	Street and Numb m, State)	per or Rura	l Route Numb	юr,
	pital o		29a. Certifier 12 Certify	ding Dhysiology To the back	of my ke-	lodge dest	agoursed at the	time det	d place	ad due to the			tatad	
	To the Hospital or Attending Physician: The law requires that the death or within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettend completely filled in by the funeral director, page 2 should be deteched for us.	edical	(Check only one)	ying Physiclan: To the best al Examiner: On the basis o and manner st	of examination	on and/or inve	estigation, in m	y opinion, dea	th occurred	d at the time,	date and place,	and due to	the cause(s)	
	Nithin To the complet	Me	29b. Signature and title of certif				29c. Lice	ense number	···········		29d. Date signe	d (Month,	Day, Year)	
	/ - 0		P.+. 7	iberto ms.			D.	3146x			1/20	104		
	7/		30. Name and address of perso	1		23a) (Type, P	rint)	rux						
	3,		ROBERT LIBER	to, MD. 3508	BAW	ie 5%.	BAZTO	pul	212	224				
	Sta		31. Date filed (Month, Day, Yea		s Signatu		1 .0	_		(
	Registr	ar	JAN	1 2 3 2004 ▶	Program o	3.	ATOBALL.	7						

DHMH 16 Rev 6/95

			1 - For State Registrar	State of Marylar		artment of I		Mental Hy	rgiene2 0 0 4	01789
	Discostati		1. Decedent's Name (First, Middle, Last,)				2. Date of De Month	eath Day Year	3. Time of Death
	Physici /Medio		ADLENE	WIMER		,		Jan.	15, 2004	2:25 p ^M
1	Examin	_	4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death	1	4c. County of Death	
	Funeral Director		219-22-4613		last birthday) Yrs.	Stre If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bi (Month, D. 4/12	Harfo rth ay, Year) 9. Birth Cor 2/1925 Wes	rd place (State or Foreign intry) t Virginia
	and		Usual Residence of Decedent 10a. State 10b. County	10c. Cir	ty, Town or Lo	cation				10d. Inside City Limits
	Maryl f sho	ō	MD Harfor	d	St	reet				1 ☐ Yes 2 🔼 No
	r 28a	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of What Cou	intry?
	h with	0	728 Highland R	oad		211	54		United Sta	ates
	deat	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S. 13.	Was Decedent of I	Hispanic Origin? (Spoan, Mexican, Puerto	pecify Yes or N	o- 14. Race - Amer Black, White	
5-0036	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any niqury or other traumatic event, the Medical Evanties must be tradilled at 20m.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 【 X No If Yes, Give Year or Dates:		1⊡Yes 25 No		, , , , , , , , , , , , , , , , , , , ,	2.01	hite
2	72 ho	ted	15. Decedent's Edu (Specify only highest grad	(cation	16a. Dece	dent's Usual Occu	pation	kina	16b. Kind of Business/I	ndustry
Maryland 2121	ithin Jan "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of wor ad)		Postal Se	arri aa
2	filed w Hygier othar th		12 17. Father's Name (First, Middle, Last)		CI	erk	19 Mothade Nam	o /First Middle	, Maiden Sumame)	er Arce
anc	bafintal had of	Be	Gilbert L. B.	roals						
Ē	hould Id Ma mark matic	ဥ	19a. Informant's Name/Relationship (T)		19b. Mailir	na Address (Stree			e Wamsley ner, City or Town, State, Z	in Code)
S	nd 2 s lith ar 27 is trau		Shirley A. Joh		5783185		r Road.			1154
ē,	s 1 ar f Hea item other	1 3	20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of matory or other pla		Date	20c. Location - City or I	
e E	Pages nent of int: If it iry or o	D y	1 □ Burial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)	removal from State		Mem. G		/19/04	Bel Air,	MD
altimore,	ortan	1	21. Signature of Funeral Service Licens			2. Name and Addre	1	71 8		
ñ	B B E S		Jeffey /	Foreliel.	Н	arkins	Funera1	Home.	Inc., De	lta. PA
	Pnysician /Medical	2 1	234 Part1 Enter the disease, or complete shock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death)	ne cause on each line. a. HYPERT	th. Do not ent	er the mode of dy	ing, such as cardiac	or respiratory a	arrest,	Approximate Interval Between Onset and Death
68760,	death certificate be executed by the attending physician and butlet transit of for use as the butlet transit.	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CERER K Due to (or as a consect Due to (or as a consect d.	quence of):	sculf	R A	tcci D	DENT	
.O. Box (es that the death certifica igned by the attending pr be detachad for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ √10 9 ☐ Unknown	23c. If yes, outcome of pregnation 1 Live birth 2 Fets 4 Pregnant at time of continuous 1 Unknown	aldeath 3	∃Ectopic pregnanc ∃ Other <i>(specify)</i> _	ey .		23d. Date of delimenth	very Day Year
rds, P	quires that n signed b uld be deta	Ď	Part II. Other significant conditions co.	ntributing to death but not res	sulting in the u	nderlying cause gr	ven in Part I.	1.4	tobacco use contribute to Yes 2 No 3 □ Pro	the cause of death?
Il Records,	Physician: The law requires that the rthis certificate has been signed by th rail director, page 2 should be detach	Completed						24a. Was auto perf 1 Yes	s an 24b. Were aut prior to commed? death?	opsy findings available ompletion of cause of
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o	Physic this call dir	٦.	1 ☐ Yes 2 No '	1 Inpatient 2	28b. Time o	it 3 DOA	4 ☐ Nursing H	ome 5 Res	idence 6 Other (Spec	home
5	Jing After	o	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	Wo	ork?]Yes 2 □ No	200. Describe	now injury occurred	1101110
Division of Vital	l or Attanc after death Diractor:	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	nome, farm, sti fy)				(Street and Number or Ru wn, State)	ral Route Number,
	To tha Hospital or Attanding Physician: The lav within 24 hours after death. To tha Funeral Diractor: After this certificate has completely illed in by the funeral director, page 2	edical Ce	29a. Certifier Certifying Phy (Check only one) 2 Medicel Exami	rsician: To the best of my knotiner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the t vestigation, in my	ime, date and place opinion, death occu	, and due to the	cause(s) and manner as date and place, and due	stated. to the cause(s)
	o tha o tha omple	Mec	29b. Signature and title of certifier	and the state of		29c. Licen	se number		29d. Date signed (Month	, Day, Year)
	F 5 ⊢ ŏ		IRJOY Ra	-m		03	36846		JANUARY 19	2004
•	0		30 Name and address of person who o	ompleted cause of death (Iter		- / ./			12-11-11	~
	•		GERNAUS H. KA	NITE MENT	s. 56	292000	CURNON	KOAD 4	itite Itall n	117 7116 (
	Sta Regist		31. Date filed (Month, Day, Year)	3 20 0年 Registration	ature A.	19				

			1 - For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of I tificate of			iene 2 0 (19. No.	14 01791
Ī	Physici	an	1. Decedent's Name (First, Middle, Last) Marie Elizabeth	Waters				2. Date of Deatl Month	Day Ye	3. Time of Death
1	/Medic		4a. Facility Name (If not institution, give s			4b. City. Town.	or Location of Death	January	19, 20	004 4:00A M
	Examin	er	420 Morris Hill			Glen B	_		Anne A	
	Funeral		5, Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9	Birthplace (State or Foreign
	Director		217-28-4880	M 2√F	77 Yrs.	Months Days	Hours Mill.	April Day	5,1926	MD')
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Aaryii f aho	ō	MD Anne Aru	ndol	Glen Bu					1 ☐ Yes 2 No
	h the Maryland rr 28a-f ahow cholified at	Director	10e. Street and Number	inder	Gren bul	10f. Zip Code		10	Og. Citizen of Wha	t Country?
	death with the Maryland ms 23a or 28a-f ahow (must be notified at	<u>-</u>	420 Morris Hill	Avenue		21	060	τ	J.S.A.	
	death	Funerai		12. Was Decedent 8 Armed Forces?	Ever in U.S. 13.	Was Decedent of I	Hispanic Origin? (Spo pan, Mexican, Puerto	ecify Yes or No-		American Indian, Vhite, etc.
õ	or ite		1 Never Married 2 Married	1 ☐ Yes 2 X N If Yes, Give	lo	I ☐ Yes 2 X No		, , , , , , ,		Black
Š	d within 72 hours after death with jiene. jiene. r then "naturel", or liems 23a or the Medical Examinar must be	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:	160 Dagge	lent's Usual Occu			16b. Kind of Busine	
215-0036	in 72 n" n	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	kind of work done OO NOT use retire	during most of work.	ing	IOD. KING OF BUSIN	essindustry
7 7	d within jiene. r than "	Eo	Elementary/Secondary (0·12) 12th	College (1-4or 5	Custo	dian		N	ISA	
פ	be filed tal Hyg d othe	BeC	17. Father's Name (First, Middle, Last)			to a real feet	18. Mother's Name			
yland		70	Howard Truitt				Marguer	ite Pur	nell	
Mar	C/ 42 = 42		19a. Informant's Name/Relationship (Type							re, Zip Code 21060
	is 1 and of Health Itam 27 other tr		Sharon Waters - 20a. Method of Disposition	Daugnte	20b. Place of Dispo		Station 1		n Burni	
altimore,	Pages nent of I int: If Itu		1 Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, crem	natory`or other pla	109)		salto. C	
			 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 	90 1 1						•
ğ	permit. Departi Importi any inj		Hely t &	Nut	ter 25	01 Gwyr	nns Falls	cter ru s Pkwy	neral H	omes, Inc. , MD 21216
£.	W EN		23a. Pert1. Enter the disease, or compli	cations that caused	the death. Do not ent					Approximate Interval Between
i i	Physician		shock, or heart failure. List only on Immediate Cause (Final	A J	Thurston	(0				Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as	a consequence of):	A. C. Sand				3 years
	Examiner		Sequentially list conditions, b	Hype	rtensin	e Candu	iovalcul	an dis	esse	20 years
•	p tis	iner	if any, leading to immediate	Due to gras	a consequence of):					
	and I-tran	Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as:	a consequence of):					
8760,	cate be executed physician and the burial-transit				2 33.130 43.1130 31,1					-
28	ficate physics the l	edicai	_ d							
XON	w requires that the death certifin been signed by the attending f should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant 25	3c. If yes, outcome					23d. Date of	delivery
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 📆 No	1 Live birth 4 Pregnant at]Ectopic pregnanc] Other (specify) _	у		Month	Day Year
r Ö	at the by th	hys	9 Unknown	9□ Unknown						
	requires that the veen signed by th hould be detache	by	Part II. Other significant conditions con	tributing to death bu	ut not resulting in the u	nderlying cause gr	ven in Part I.		P.A.	e to the cause of death?
Hecords	requii	Completed						1 Te	s 210 No 3	Probably 4 Unknown
ec C	elaw hasb e2st	npie				-		24a. Was an autopsy perform	y prior	autopsy findings available to completion of cause of
	sician: The law certificate has E irector, page 2 s							1 Yes 2	No 1□	Yes 2□ No
Vital	Physician: this certific ral director.	o Be	25. Was case referred to medical examiner?	lospital:		Ottora Ot	her:	Table Christia		
o	> .∞ ♥	1-	1 ☐ Yes 2 ②No 27. Manner of Death	28a. Date of Injur	nt 2 ER/Outpatien y 28b. Time of	28c. Inju	ary at	28d. Describe ho	nce 6 Other (s	Specify)
UNISION	Attending ir death. ector: After by the fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Da)	Year) Injury		ork?]Yes 2∐No			
NIS	r Atte er de recto by th	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju-	ury - At home, larm, str	eet, lactory, office		28f. Location (Str. City or Town,		r Rural Route Number,
5	ital or rs aft ral Dii led in	Cer		January, ord	(0,200)/			o.,, o. , o		
	Hospi 4 hou Funer ely fill	edical	(Check only 2 Medical Examin	ner: On the basis of	of my knowledge, death examination and/or in	occurred at the treestigation, in my	ime, date and place, opinion, death occurr	and due to the ca	use(s) and manne ate and place, and	r as stated. due to the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Med	one) 29b. Signature and title of certifier	and manner sta	ted.		se number		d. Date signed (M	
	F. M. F. S		bl. Leu		-MD	D	1774	3	01/21	104
	N		30. Name and address of person who co	mpleted cause of de	eath (Item 23a) (Type	Print)	, , ,		1	1 - 1
	1		L. SEENIVASAN		06 HAMM	ONDS LA	NE, Suite	21-6.	BALTO	MD, 21225
	Sta	ite	31. Date liled (Month, Day, Year)	32. Registra	ar's Signature	,		1		
1.5	Registr	rar	18N 9 9 2004	Bome Land	1 19 1	loo VI				

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Warner 2:40 January 20 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hopkins Bayriew Medical Center Bultimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country), **Funeral** 1 □ M 2 F Days Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or than "natural", or Itams 23s or 28s-f show the Medical Examiner must be nutified at Yes 2 No ND by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 51 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Marned 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify: WHITE 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other treumatic event, 17. Father's Name (First, Middle, Last) Be WARNER 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address Street and Number or Rural Route Number, City or Town, State, Zip Code) ONCA if item 27 l 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Pages 1 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State injury or ` 4 ☐ Donation 2004 22. Name and Address of Facility 829 HUD SOL 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disea e. / r complications that caused the death. Do not enter the mode of dying, such as cardiac or respire ony arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pespiratory Physician /Medical Examiner Some titally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-transit Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No į Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown ate has been signed | page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Immunodeficiency 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ⋈ No To the Hospitel or Attending Physician: funeral director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 ☐ Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my color 29a. Certifier (Check only one) Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatul RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Md Dr. John Eckman 4940 Eustern 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2 3 2004

DHMH 17 Rev 1/2001

Registrar

		4	For State Registrar	State of Maryland		ent of Health a ate of Death	and Mental I	Hygiene Reg. No.	2004	01792
	Physicia	an	1. Decedent's Name (First, Middle, Las		LLIN	GER	2. Date of Month	Death Day	2004	3. Time of Death?.
	/Medic Examin		4a. Facility Name (If not institution, give			ity, Town, or Location of	OPER CIVER	46.	County of Death	. Co .
å	Funeral Director		2/3-20-4471	7. Age (In yrs. last	yrs. If Ur	hs Days Hours	Min _ (Month	Birth Day, Year)	Cou	place (State or Foreign ntry)
	Aaryland f ahow ed at	or	Usual Residence of Decedent 10a. State 10b. County	4.4	Town or Location	RIVER				10d. Inside City Limits 1 Yes 2 □ No
	with the Page or 28a-	i Direct	10e. Street and Number 9 Mari Froi	DIT		Zip Code		10g. Citiz	zen ol What Cou	ntry?
io.	hours after death with the Maryland tural; or Itama 23a or 28a-f ahow al Evandur roust be colified at	Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 22 No If Yes, Give		ecedent of Hispanic Original Specify Cuban, Mexican Specify:	gin? (Specify Yes o , Puerto Rican, etc.)	14. Race - Ameri Black, White	
215-0036	"natural",	Completed by	3√Widowed 4 □ Divorced 15. Decedent's Ed (Specify only highest gra	Year or Dates:	16a. Decedent's		t of working		nd of Business/in	1 TE
2	be filed within 72 ho ital Hygiene. d other then "natu event, the Med cal		Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	MANL	FACTUR	ER or's Name (First, Mic			ELEC.
Maryland		To Be	GEORGE 19a. Informant's Name/Relationship (BOWERS	19b. Mailing Add	NE ress (Street and Number	TTIE	DOUG umber, City o	SLAS TOWN, State, Zi	o Code)
	s 1 and 2 she of Health and Itam 27 Is m other traum		WINDA WILL 20a, Method of Disposition	INGER 200. Pla	9 MAL	FORD C		To.,	11-	21220
Baltimore,	Pages ment of ant: If It ury or o		1 Burial 2 Cremation 3 Donation 5 Other (Specify	() Special from State	HEART	or other place) of JES 05 e and Address of Facility	AV 2004	BA	HTO.	MD.
Ba	permit. Departi Import any inj		21. Signature of Juneral Service Licen	- Sparka	1. SKA	RDA F.H.	DALT	MOK	E, HD	Approximate
	Physician		23a. Part1. Enter the disease, dr.com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	~	,	cardiac or respirato	ry all 651,		Interval Between Onset and Death
ý	/Medical Examiner		resulting in death) Sequentially list conditions,	Due to (or as a conseque						
	and I-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
68760,	icate be executed physician and s the burial-transit	icai	· ·	d						
.O. Box 6	The law requires that the death certificate be executed at has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 □Ector	oic pregnancy r (specify)		_	23d. Date of delik Month	very Day Year
s, D	quires that I n signed by uld be deta		Part II. Other significant conditions of	contributing to death but not resul	lting in the underly	ing cause given in Part I		Did tobacco u		the cause of death?
Vital Record		Completed						Was an autopsy performed? les 2 □ No	prior to o	opsy findings available ompletion of cause of 2 No
f Vita	Physician: The lav this certificate has ral director, page 2	To Be	25. Was case referred to medical examiner? 1 Yes 27 No	Hospital: 1 Inpatient 2 E	ER/Outpatient 3[Other	of Death (Check oursing Home		6 ☐ Other (Spec	ufy)
Division of	To the Hospital or Attending Physic within 24 hours after death. To the Funeral Director: After this ce completely filled in by the funeral direct	Certification:	27. Manner of Death Natural 5 Pending Accident investigatio Suicide 6 Could not be	(Month, Day Year)	28b. Time of Injury M		No	ribe how injur		
DIVI	ital or Ati its after d ral Direct led in by		4 Homicide determined	building, etc. (Specify,)		City o	r Town, State)	rai Route Number,
	the Hosp in 24 hou the Fune spletely fil	ledicai	(Check only 2 Medical Example)	nysician: To the best of my know miner: On the basis of examinati and manner stated.	vledge, death occu ion and/or investig	ation, in my opinion, dea	nd place, and due to ath occurred at the t	ime, date and	d place, and due	to the cause(s)
	To To	×	29b. Signature and trie of certifier	, M D		29c. License number D00338	-47	1/2	to signed (Month	, Day, rear)
	Vo		30 Name and address of person who	3509 Easte-	23a) (Type, Print)	D00338	ore, mo	נבוב.	1	
2.	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure					

State of Maryland / Department of Health and Mental Hygiene? 793 State RegistraMEND ITEM #10e PER FH G827 1/23/04 Grentificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 1:15 PM Jan. MYRA WAGONHEIM 20 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** tealthcare Battmore
If Under 1 Year If Under 24 Hrs. N/A Agnes 8. Date of Birth (Month, Day, Year) SEP.25,1928 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Days 1 □ M 2 🙀 F Yrs. 217-58-6473 75 MD Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE BALTIMORE 10e. Street and Number 8203 CRANWOOD COURT 10f. Zip Code 10g. Citizen of What Country? ltems 23a or 8203 CRANSWOOD COURT 21208 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "naturel", or 1 ☐ Yes 2 🕅 No WHITE δ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PROPERTY OWNER REAL ESTATE Pages 1 and 2 should be filed w treent of Health and Mental Hygier tent: if item 27 is marked other th jury or other treumatic event, ILs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MILTON SCHWABER CECELIA SAKOLSKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARK WAGONHEIM / SON 38 RAISIN TREE CIRCLE - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. ARLINGTON CHIZUK AMUNO 1/22/2004 BALTIMORE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Electron 22. Name and Address of Facility SOL LEVINSON & BROS.. INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) lung Cancer non-small cell **Physician** 6 years /Medical Due to (or as a consequence of) Examiner Securities list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner use as the burial-transit The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-traresulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform this certificate has 1 Yes 2 No After this certifica funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑No 3□ DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospitel or Attending 1. □Naturai 2 □ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation the Director 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) D35254 Tanua 20 200-30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) 900 Catin Que BALT MO 21229. aroleMiller 32: Registrar's Signature State JAN 2 3 2004 Registrar

DHMH 17 Rev 1/2001

lyra Wagonheim

State of Maryland / Department of Health and Mental Hygiene

				Certificate	e of Death	Re	g. No.	4 01/94
	Physician	1. Decedent's Name (First, Middle, L	ast)			2. Dete of Deeth	Day You	3. Time of Death
was a	/Medical	Mary weaver				Januar	y 16 , 200	4 8:00 AM
+	Examiner	4a Fecility Name (If not institution, g				Location of Deeth	4c. County of De	
		Heartland Health			Adelpl		Prince G	eorges
	Funeral Director	5. Social Security Number 6. 577-42-6021 Usuel Residence of Decedent	404 405	4 Yrs. If Under Months	1 Year If Under 24 Hrs Days Hours Min		Year) 9. B 1909 Ma	hirthplace (State or Foreign Country) ryland
	pue *	10a. Stete 10b. County	10c. 0	City, Town or Location				10d. Inside City Limits
	Aenyl taho	3.65	George's	Adelphi				1 ☐ Yes 2√ No
	the the table to the table to the table to table	10e. Street end Number		10f. Zip	Codo	10	- Ciainan of tall at	
	after death with the Mei or Neme 23e or 28e-fs riner must be notified Funeral Director	1801 Metzerott			20783		g. Citizen of Whet (USA	
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. Important: if I lem 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Maritel Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes:		lent of Hispanic Origin? (sify Cuban, Mexican, Puer 2017) No Specify:	Specify Yes or No- rto Rican, etc.)	Black, Wh	nerican Indian, nite, etc. black
5	72 h Inatu	15. Decedent's E (Specify only highest g	ducation rade completed)	16a. Decedent's Usua (Give kind of wor	I Occupetion	orkina 1	6b. Kind of Busines	s/Industry
121	/ithin	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT us	k done during most of wa se retired)	, iking		
2	Co.	12	0	maid				esidences
Maryland	d off	17. Fether's Name (First, Middle, Las	t) .			me (First, Middle, M	•	
ž	should to marked umartic	Carroll Young				ry Brisco		
<u>Ra</u>	12 sh end ie m raum	19a. Informant's Name/Relationship Frances L. Young			(Street and Number or Re			
	1 end lealth m 27 ther tr				th Carolina			
Baltimore,	Pages ment of h	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☑ Other (Special Content of the Conte	Removal from State	Place of Disposition (Nam cemetery, crematory or ot-	e or her place)	Date 2	Oc. Location - City o	r Town, State
Ball	pemit. Page Department or Important: if any injury or once.	21. Signature of Funera Service Lice Ropald S	Wade Directo	or State A Baltimo	Address of Facility Anatomy Boar Ore, MD 212		Baltimore	Street
	Physician	23a. Part . Enter the disease or unshoot, or heart failure. List only	plications that caused the dea one cause on each line.	ath. Do not enter the mode	of dying, such as cardiac		it,	Approximate Interval Between Onset and Death
	/Medical	Immediate Cause (Final disease or condition	S	epsis.				
24.	Examiner	resulting in death)		(or as a consequence of):				1
	<u> </u>							1
	entificete be executed fing physician end se as the bunel-transit	Sequentially list conditions,	D. Due to	(or as a consequence of):				
တွ်	cian cian ounel	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	•					
68760,	sete the physic the contract of the contract o	that initiated events resulting in death) Last	Due to (or as a consequence of):				
9 ×	leath certifice attending ph I for use as t		d					1
Вох	ath c or us		<u> </u>					
o	of the death c d by the attend leteched for us Physiciary	Part II. Other significant conditions	contributing to death but not re	sulting in the underlying ca	use given in Part I.	23b. Did toba	acco use contribut	e to the cause of death?
s, P.O.	requires that the death certificate be executed been signed by the attending physician end should be deteched for use as the bunel-transit eted by Physiclan/Medical Examir	Advance	ed Deme	nha		1 🗌 Yes	2□ No 3□ F	Probably 4 Unknown
of Vital Records,	aw 2 s L					24a. Was an a performe	autopsy 24b. d?	Were autopsy findings available prior to completion of cause of death?
<u> </u>	The law ate hes b page 2 s					1 ☐ Yes	2 No	1 ☐ Yes 3 ☐ No
<u>=</u>	ician: The certificate rector, pag	25. Was case referred to medical examiner?			26. Place of Dec	eth (Check only one)		
-	Physician: rthis certific and director.	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient 3☐ DOA	Other: 4 Nursing H	lome 5 Residence	e 6 □Other (Spe	ecify)
onois	Attanding Pi ir death. Detor: After th by the funera Ification:	27. Menner of Death 1.∠Natural 5 ☐ Pending 2 ☐ Accident investigatio		28b. Time of Injury M	c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how		
	tal or Attanding P rs after death. at Director: After t led in by the funers Certification:	3 Suicide 6 Could not b	e 28e. Plece of Injury - At h building, etc. (Speci	nome, farm, street, factory,	office	28f. Location (Stree City or Town, S	et and Number or R State)	ural Route Number,
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be (29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exar	ysician: To the best of my known of the basis of exeminating and manner stated.	owledge, death occurred et ation and/or investigation, in	the time, date end place, n my opinion, death occur	, and due to the caus rred at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)
	To the Com	29b. Signeture and title of certifier	- Comment		License number	29d	Date signed (Moni	
				0	0005456	6 /	116104	
-10		30. Neme and address of person who		m 23e) (Type, Print)				
		Sunitera Blogavi	wi, 1220A East	Joppa Road	Scih 230,7	Towson.	MD 2128	36
	State Registrar	31. Date filed (Month, Day, Year) JAN 2 3 200	32. Registrar's Sign	ature				

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Williams Month Day Year 2004 **Physician** Curtis 6:49 AM January 21 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center Baltimore 8. Date of Birth Month, Day, 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Months Hours 1 M 2□ F 249-46-547 Director South Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State item 27 is marked other than *naturel', or Items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Director Maryland the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2563 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X(Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2. No Specify If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ges 1 and 2 should be filed within t of Health and Mental Hygiene.
If item 27 is marked other than * Elementary/Secondary (0-12) College (1-4or 5+) zenera 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) em Davis iams (wife) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 563 2 000 Department of Heal 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 28 12004 forest 22. Name and Address of Facility
Joseph L. Kuss Ful
2222 W. North Ave. 21. Signature of Funeral Service Licenses ral Home era 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician anoxic brain INTORY /Medical Due to (or as a consequence of): Examiner myocardial Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner burial-transit W athero clero Councir led by the attending physician and detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? چ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown ension Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 Tes 2 1 No filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ☐ ★6 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Matural after death. М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the

31. Date filed (Month, Day, Year) Registrar JAN 2 3 2004

29b. Signature and title of rtifier

N.D.

32. Registrar's Signature OCAKA

Bayview Medical Center, 4940 Eastern Avenue, Baltimore, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joshua Bernstein,

DHMH 17 Rev 1/2001

29c. License number

res-000

29d. Date signed (Month, Day, Year)

Johns Hopkins

January

MID

21,2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Watson Yeer 01:45AM Horence January 20,2004 /Medical 4b. City, Town, or Location of Death 4e. Fecility Name (If not institution, give street and number) Examiner Hospital Baltimore The John Hopkins If Under 1 Year | ff Under 24 Hrs. 8. Date of Birth Month, Dey, Ye July 26, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** , 1948 South Days 242-80-3046 Usuel Residence of Decedent 1 □ M 2 🗙 F Yrs. Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23s or 28s-f show other traumatic avant, the Medical Example: must be notified at 1 Yes 2 □ No by Funeral Director Naryland
10e. Street and Number more 10g. Citizen of What Country? 10f. Zip Code 212 Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 14. Race -1) Never Married 2 Married 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced other than "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) . Pages t and 2 should be fill thent of Health and Mental H tant: If Item 27 is marked other Informant's Name/Relationship (Type, Print) 19b. Mailing Address (street and Number or Rural Route Number, City or 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 1 8urial 2 ☐ Cremation 3 Removal from State permit. Page Department o Important: If any injury or injury or Mem. Gardens * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death snock or heart taily Immediate Cause (Final disease or condition resulting in death) Carcinoma Breast **Physician** 5 yeurs /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): use as the burial-transit the attending physicien and Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown as been signed by 2 should be detact Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform page 2 No 1 Yes 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital Other: Certification: To 1 ☐ Yes 2 No 1 Xinpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) Mudum Shmed, Medical Doctor P16698 January 20, 2004

Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, certificate has After this Diractor: To the Hospital within 24 hours a To the Funeral D

Baltimore, Maryland 21215-0036

3

DHMH 17 Rev 1/2001

State Registrar

Dr. Nadeen 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

Bultimore Annel, The John Hopkins Hospital, 600 North Wolfe street Marjund

			Tease 1 1 - State Registrar	• •	ryland / Depa Cei		lealth and M	1ental Hygi		04 01797
100	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give s JOHNS HOPKINS HO	street and number)			r Location of Death	2. Date of Death Month	Day 2	Year 3. Time of Death Of Death A M
	Funeral Director		5. Social Security Number 214-38-2143 Usual Residence of Decedent	7. Age	(In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 11-21-		Birthplace (State or Foreign Country) NORTH CAROLIN
	n the Maryland r 28a-f ehow	Director	10a. State 10b. County MD • N/A		10c. City, Town or Lo			10	g. Citizen of V	10d. Inside City Limits 1 1 Yes 2 No What Country?
036	within 72 hours after death with the Maryland ane. then "natural", or iteme 23e or 28e-f ehow ite Medical Exama et must be multified at	by Funeral	1818 HARFORD AVE 11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced	• 12. Was Decedent E Armed Forces? 1 ∐Yes 2 ∑N If Yes, Give Year or Dates:	0		213 lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Blac	e - American Indian, k, White, etc.
Maryland 21215-0036	filled Hygin Sther	e Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) -12- 17. Father's Name (First, Middle, Last)	cation a completed) College (1-4or 5-	(Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of work d)	ing	DON	Siness/Industry SESTIC e)
larylan	2 should be and Mental is marked c	To Be	ROBERT CLARK SR. 19a. Informant's Name/Relationship (Ty)	· ·			DORA C	al Route Number,		
Baltimore, N	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tropoca.		LINDA E. CLARK (D 20a. Method of Disposition To Burial 2 Termation 3 R 4 Donation 5 Other (Specify) 21. Signatury Period Service Conse	emoval from State	20b. Place of Dispo cemetery, crem MT. ZION D. HIBNER ²²	sition (Name of natory or other place CEMETERY Name and Addre	1-24-	2004 B. LLIPS FU	Oc. Location - ALTIMOF NERAL F	
	Pnysician /Medical		23a. Parl. Enter the disease, or complished, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	. Pulmo	the death. Do not ent					MARYLAND 21217 Approximate Interval Between Onset and Death
760,	te be executed ysician and burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last		consequence of):					
.O. Box 68	death certifica e attending ph od for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	Fetal death 3	Ectopic pregnancy] Other (specify)			23d. Dat Mor	e of delivery oth Day Year
rds, P	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions con	tributing to death bu	t not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did toba	/	ibute to the cause of death? 3 Probably 4 Unknown
of Vital Records,	The ate h page	e Completed	My persons in Negatives 125. Was cas referred to medical	ie Juni	- biseas	1			ed? d	Vere autopsy findings available rior to completion of cause of eath?
ion of Vi	N S P	ertification: To B	examiner?	ospital: 1 Inpatier 28a. Date of Injun		28c. Injun Wor	er: 4 Nursing Ho	me 5 Resider 28d. Describe hov	nce 6 Othe	
Division	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	O	3 Suicide 6 Could not be determined	building, etc.	ry - At home, farm, stre (Specify)			City or Town,	State)	er or Rural Route Number,
	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medical Examirone) 29b. Signature and title of certifier	ner: On the basis of and manner stat	examination and/or inv	vestigation, in my o	pinion, death occurr	ed at the time, dat	e and place, a	(Month, Day, Year)
)	2		30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Type,	Print)	059300	04	1/21/	2004
	Sta Regista		31. Date filed (Month, Day, Year)	32, Registra	r's Signature	E.Eagle	NST. B.	ilhmore	LIMD	21202

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dey ST Month **Physician** 2000 Du Ri Yi c-nnow /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (ff not institution, give street and number) Examiner ARUNDEL GLEN BU BURNIE ANNE ARUNDEL NORTH HOSPITAL 5. Social Security Number Birtoplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 TF 75 Yrs. 213-08-3304 Director June 4. Korea Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show 7 is marked other than "natural", or flems 23a or 28a-f shor traumetic event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Maryland Funeral Director Anne Arundel Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7405 Beclare Court 20794 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2/2XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 end 2 should be filed within 72 hours after to Department of Health end Mentel Hygiene. Important: If itsm 27 is marked other than "natural", or han any Injury or other traument. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XXNo Specify. Specify: Asian Be Completed by 3 NWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jong Man Yi Kim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sun Cha Walker - Daughter 7405 Beclare Court Jessup, Maryland 20794 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Pk. 1/23/04 Elkridge, Maryland Gary L. Kaufman Funeral Home At MMP., Inc. 21. Signature of Funeral Service Licenses 7250 Washington Blvd. umay Elkridge, Maryland 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner or Attanding Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of). Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 🗌 Yes 1 ☐ Yes 2 No certificate ours after death.

eeral Director: After this certifical filled in by the funeral director. 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient Medical Certification: To 1 Yes 25 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital o within 24 hours af To the Funeral Di completely filled in 29a. Certifier া 🗲 criffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2004 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) BOM 3V 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

ORIGINAL

DHMH 16 Rev 6/95

Williame

29d. Date signed (Month, Day, Year)

O.C.M.E.

January 10, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYSUM

111 Penn Street, Baltimore, Maryland 21201

State Registrar My)

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JANUARY 11, 2004 MARTE LILY LEWIS BOLDEN 5:45 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES GLADYS SPELLMAN SPECIALITY HOSPITAL & NURSING FACILITY CHEVERLY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Park 10, 1947 NORTH CAROLINA 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Days 1□ M 2 → F Yrs. 244-76-5037 56 Director Usual Residence of Decedent 1 end 2 should be filad within 72 hours after daath with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 ☐ Yes 2 No CHARLES LAPLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20646 UNITED STATES 7745 HAWIHORNE ROAD Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Completed by 3 ☐ Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be end Mantal Is marked of MARY ELIZABETH JAMES EADDY BENJAMIN JENKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARRY L. BOLDEN/HUSBAND Health em 27 i 7745 HAWIHORNE ROAD, LAPLATA, MD 20646 20b. Place of Disposition (Name of Pages 1 20a. Method of Disposition 20c. Location - City or Town, State Department of important: If it any injury or conce. cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dopration 5 ☐ Other (Specify) MD VEIERANS CEMETERY 1/15/2004 CHELTENHAM, MD 21. Signature of Funeral Service Licens THORNION TUNERAL HOME, P.A. LXDIA C. THORNION JOHNSON 3439 LIVINGSION ROAD, INDIAN HEAD, MD 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) a. STAPH SEPSIS Examiner Due to (or as a consequence of): Physician/Medical Examiner CONGESTIVE HEART FAILURE attanding physician and for use es the burial-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. CORONARY ARTERY DISEASE that initiated events resulting in death) Last Due to (or as a consequence of) HYPERTENSIVE CARDIOVASCULAR DISEASE Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? cate has been signed by page 2 should ba dated 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 🍂 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 1x Inpatient 2 ER/Outpatient 3 DOA Director: After this 27. Manner of Death ate of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours aftar death. To the Funeral Director: A 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 027577 Trim (Type, Print) 8416 CENTRAL AVE. OPHNELL CUMBERBATCH, MDLANDOVER, MARYLAND 31. Date filed (Month, Day, Year) 32. Restrar's Signature State Registra

DHMH 16 Rev 6/95

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment rtificate			F	Reg. No.	04	0.801
			1. Decedent's Name (First, Middle, Last)	_					2. Date of Dea Month	th Day	/Year	3. Time of Death
	Physici /Medi		Mazgazet (E. BRO	ensom				DL	1 09/	04	1425 PM
7	Examir		4a. Facility Name It not institution, give s	treet and number)	-1 /	4b. City, To	own, or Lo	cation of Dea	ith /	4c. County	of Death	
	_xann		Cheston River L	herital	Center	Ch	05/0	RHOW	K	Ke	ut	
	Funeral		5. Social Security Number 6. Sex		e (In yrs. last birthday	If Under 1		Under 24 Hr		Year	9. Birth	place (State or Foreign
	Director		577 18 9741 1 ⁻¹	M 283 F	84 Yrs.	Months 0	Days	Tours Mill	Oct 28	1919	Mar	ÿland
			Usual Residence of Decedent									
	ylan		10a. State 10b. County		10c. City, Town or L	ocation						10d. Inside City Limits
	Mar 1 s	tor	MD Kent		Worton							1 ☐ Yes 2 No
	128.	rec	10e. Street and Number			10f. Zip C	ode			10g. Citizen of \	What Cou	ntry?
	3a o	by Funeral Director	13361 Fishing Val	ley Road		21	.678			United	Stat	es
	TIS 2	era		2. Was Decedent I	Ever in U.S. 13.	Was Deceder	nt of Hispa	anic Origin? (Specify Yes or No- nto Rican, etc.)	14. Rac		can Indian,
10	r Iter	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X		_			no Hican, etc.)		ck, White,	etc.
33	urs a	by	3 ☐Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 Yes 2	_XNo S	Specify:		Specify	v: Wh	ite
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28e-f show diesi Examinat must be rediffed at	Completed	15. Decedent's Educ		16a. Dece	dent's Usual (Occupation	n	and the same	16b. Kind of B	usiness/In	dustry
7	n''n Nedi	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	life.	e kind of work DO NOT use	retired)	ng most of wi	DIKING			
212	in with a special section of the sec	E O	unknown	Comogo (1 45. c		memaker				Own I	10me	
	Hyg othe	Be C	17. Father's Name (First, Middle, Last)				18.	. Mother's Na	me (First, Middle,	Maiden Suman	ne)	
an	ld be enta ked ic ev	To B	unknown El	lis			ı	unknow	n E	Bryant		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Importants if Item 27 is marked other than "natural", or Items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be rediffed at ARCS.	-	19a. Informant's Name/Relationship (Type	ов, Print)	19b. Mail	ing Address (S	Street and	Number or F	Rural Route Numbe	r, City or Town,	State, Zip	Code)
Ž	ith a		Clifford J. Gladu	/Son	13363	l Fishi	ng Va	alley	Road Wort	on, MD	2167	8
ē	Hea Hea tem		20a. Method of Disposition		20b. Place of Disp cemetery, cre	osition (Name	of	-	Date	20c. Location -	City or To	own, State
Baltimore,	ages int of t: If i		1 Burial 2 □ Cremation 3 □R 4 □ Donation 5 □ Other (Specify)	emoval from State	Mt. Zion			rvi 1–1	3-2004	Highlar	nd. M	ID.
Ħ	it. Purtme	1 12	21. Signature of Funeral Service License	mΩ	1044	2 Name and	Address o	of FacilityHa	rry H. Wi			ly FH Inc.
Ba	Departiment of the policy in policy		St. Colla	-429					Pike Elli			
			23a. Part1. Enter the disease, or compli	actions that sauced								Approximate
			shock, or heart failure. List only or	e cause on each lir	70.	_	:	don as oar die	to or respiratory arr	031,		Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	⊀∢	2s pivator	y fai	luve	2				7 days
	/Medical Examiner		resulting in death)	Due to (or as	a consequence oi).		0	-				•
	LAdminer		Sequentially list conditions,		c Obstruc	ive the	lmon	avy 1	Disease			
	Q =	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):							
	acute Ind trans	am	Cause (Disease or injury that initiated events resulting in death) Last									
ó,	be executicien and burial-tran		resulting in dealin, cast	Due to (or as	a consequence of):							
3760,	lys BC	Ical										
89	tific g p	Completed by Physician/Med	IF FEMALE:									
Вох	th ce tendi	an/I	23b. Was decedent pregnant	3c. If yes, outcome 1☐Live birth		□Ectopic preg	nancy				te of delive onth	ery Day Year
	ne dea the at hed fo	sici	in the past 12 months? 1 ☐ Yes 2 No	4☐ Pregnant at 9☐ Unknown	time of death 5	Other (spec	ify)			1610	7711	Duy Gai
P.0	ac oc	hy	9 Unknown						T			
	signed to d be det	by F	Part II. Other significant conditions con	-1.	4		-	n Part I.				he cause of death?
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သို့	s be	plet	OSteoporosis:	Achol 7	GERD				24a. Was a	an 24b.)	Were auto	psy findings available mpletion of cause of
Ä	The law	E		,	7				perfor	med?	death?	2□ No
ta		(a)	25. Was case referred to medical				26	6. Place of De	eath (Check only or			
>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	ospital:	nt 2 ER/Outpatie	nt 3 DOA	Other:	4 🗋 Nursing	Home 5 ☐ Reside	ence 6 Oth	er (Specif	iv)
0	ding Phys n. After this funeral di		27. Manner of Death	28a. Date of Injur (Month, Day	ry 28b. Time (of 280	: Injury at Work?		28d. Describe h	ow injury occurr	red	
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Division of Vital Records,	Attending r death. ector: After by the fune	Hice	3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At home, farm, s	treet, factory, o	office		28f. Location (S. City or Town		er or Rura	al Route Number,
Ö	afte Dire	Certification;	4 Homicide	building, etc	с. (Зреспу)				City of Town	n, Sialej		
	spits nours nera / fille	al			of my knowledge, dea							
	e Ho 24 t a Fu letely	edical	(Check only 2 Medicel Examinations)	ner: On the basis of and manner sta	f examination and/or in ated.	nvestigation, in	n my opinio	on, death occ	urred at the time, d	late and place,	and due to	the cause(s)
	To the Hospital or Attendi within 24 hours after death. To tha Funeral Director; A completely filled in by the fu	B	29b. Signature and title of certifier			29c. t	License nu	umber	2	9d. Date signed	d (Month,	Day, Year)
	> 0		Dara Cara	20D1		D	509	796		1/9/20	004	
6	1.2		30. Name and address of person who co	mpleted cause of d	eath (Item 23a) (Type							
6	ا الما ا		NeilStadday	- LUD	100 Bro	wn S	to C	leaste	er town	LUD Z	216	50
	Sta	ate	31. Date filed (Month, Day, Year)		ar's Signature	1						
	Regist	727	.IAN 1 Z / U	114	ALL LA	103BARO 1						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Rosaria H. Calabrese January 1Ó 2004 3:15 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3717 Dorsey Search Circle Ellicott City Howard 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, May 10, 9. Birthplace (Stete or Foreign Country) Maryland **Funeral** Days 1 ☐ M 2 🔀 F Director 1929 218 28 6037 74 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 28e-f ahow 10d. Inside City Limits event, the Mudical Exeminer must be notified at Director 1 Yes 2 No MD Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 3717 Dorsey Search Circle or items 23a 21042 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: Specify: 3 Widowed 4 Divorced Year or Dates: "natural", White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookkeeper State of Maryland Department of Heatth and Mental Hygie important: If Item 27 is marked other any injury or other traumatic event, IL ODGE. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Pietro Calabrese Rosina Glorioso ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3717 Dorsey Search Circle Ellicott City, MD 21042 Anthony A. Calabrese/Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Rother (Specify) entombment Loudon Park Cemetery 1-14-2004 Baltimore, MD permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ONDIEC covery /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Due to (or as a consequence of). Examine anding physicien and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐Ectopic pregnancy for Month Day 4☐Pregnant at time of death 5 Cther (specify) P.O. I ed by the a detached f 1 ☐ Yes 2 🖾 No 9 Unknown 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy performed? certificate 1 Yes 2√2 No or Attending Physician: tuneral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) Hospital: To. 1 Yes 2 No s after death. el Director: After ti 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a the Hospitel 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely and manner stated. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 0055171 January 12, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3023 EASTERN AVENUE SEBASTIAN JOHN BALDIMORE MD 31. Date filed (Month, Day, Year) 32. Segistrar's Signature State 12 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Hackney Kate Dixon 5:00 PM M Jan 12. 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7904 Surrattes Road Clinton Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 40 # 6158 72 Director Feb 12, 1931 North Carolina Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ust be nutilied at 1 Yes 2 No Director Maryland Prince George's Clinton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 23a 7904 Surratts Road 20735 death Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? or itema 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status The Madical Examinist filed within 72 hours after 1 ☐ Yes 2 TNo If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No þ If Yes, Give Year or Dates: Specify Specify: 3XWidowed 4 ☐ Divorced White "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Seamstress Commerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be finent of Health and Mental I and: if Item 27 is marked or William Hackney Fannie Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce W. Cooke (Son) 26867 North Sandgates Road, Mechanicsville, RD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ot once. 1 Burial XXCremation 3 Removal from State
4 Donation 5 Other (Specify) Lee Crematory Jan 14, 2004 Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licensee M00542 Alexandria Ferry Road, Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARtivioscleruta Hant Physician disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Box 68760 Physiclan/Medicat as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐ Pregnant at time of death 9☐ Unknown 5 Other (specify) P.O. ☐Yes 2☐No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 200 No 1□ Yes ector. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 | Inpatient Other: 4 Nursing Home 12 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA this Certification; 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Solatural 2 Accident 3 Suicide 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: d in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hin 24 hours ... o the Funeral Dirr 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) 2 Juney D35206 JANUM 14, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tanner, M.D. 11701 Livingston Road, #101, Fort Washington, MD20744 William 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2004 2003 ALBERT AUSTIN DODDS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Worcester Atlantic General Hospital Berlin If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 XM 2 ☐ F Yrs. 90 7/10/1913 NJ 066-10-3236 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location rthan "natural", or Items 23a or 28a-f shov The Medical Exercises must be notified at 1X Yes 2 ☐ No Ocean Pines Worcester Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21811 26 Carriage Lane Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Vice President Shirt Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If item 27 Ia marked oth any injury or other traumatic event 2002s. Be Albert Avery Dodds Jennie Christy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Windjammer RD Ocean Pines, MD Judith D. Ferdinand 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Cemetery 1/12/04 Mahwah, NJ Maryrest 21. Signature of Manera Sirvice Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William st. Berlin, MD mbal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 030150X **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Jecuse or night that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No rmed? 1□ Yes Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Certification: To Be Hospital: 1 Lealient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Divo 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death July - 10-1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signatur and title of certifier 29d. Date signed (Month, Day, Year) who compeleted cause of death (Item 23a) (Type, Print) Doschulia 32. Segistrar's Signature 31. Date filed (Mont State Registrar

Chaine

		1- For Amend Item 26 per Registrar	State of Maryla GS/DVRG827,01	723/04db	rtificate	t of He	eaith a leath	and M	ental Hyc			3. Time of Death
Phỳsi	cian	1. Decedent's Name <i>(First, Middl</i> e, <i>Last)</i> Violet Blai	nche Louis	se Duv	<i>r</i> a11				January		2004	11:50 FM. M
/Med Exam		4a. Fecility Name (If not institution, give s 12635 Munmert 1	reet and number)		4b. City,	Town, or L Clea		of Death Oring	5		unty of Deeth Washin	
Funera Directo		5. Social Security Number 6. Sex 220-28-2765	M 2127 F 7. Age (In y	rs. last birthday, Yrs.	If Under Months	1 Year Days	Hours	24 Hrs. Min.	8. Date of Birt eD 22	, Y91922	9. Birth	place (State or Foreign
death with the Maryland ma 23a or 28a-f show	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Washing 10e. Street and Number		City, Town or L	ocation Clear					10g. Citizen	of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
h with 23a or	ai Dir	12635 Mummert Road					217	722			U.S.A	A.
ē 5	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Nover Married 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	n U.S. 13.	Was Deced If Yes, spec		panic Orig , Mexican Specify:	gin? (Spe i, Puerto I	cify Yes or No- Rican, etc.)		Race - Amer Black, White ecify: Wh	
e tiled within 72 hours atter al Hygiene. other then "naturel", or Ita	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us nemake	rk done du se retired)	ion i <i>ring m</i> ost	t of workii	ng		of Business/li	ndustry
be tile be oth	To Be C	17. Father's Name (First, Middle, Last) Claude Daniel Sier					18. Mothe		(First, Middle, ettie B			ins
Mary nd 2 sho ulith and 1 27 is mu		19a. Informant's Name/Relationship (Typ Parnela Sue Weddle/	oe, Print) Daughter	19b. Mail 126.	ing Address 35 Mun	(Street ar mert	Roac	or or Rura	Route Numbe Lear Sp:	r. City or To	MD 21	ip Code) 722
Deficiency of the post of the		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □R '4 □ Donation 5 □ Other (Specify)	20) emoval from State	b. Place of Disp Mount O	osition (Nar. Matory of o LTVEL	ne of ther place Ceme	tery		. 19, 2	20c. Locat 004 F1	ion - City or T cederic	own, State ck, MD 21701
permit. Pages Department of I Important: If its	ig and the second	21. Signature of Funeral Service License	neul 0	MOO02	2. Name an 1 K ∈	eenev	and	Basi	ford Fu	neral t Ero	Home	z MD 21701
ilicate be executed /Medica Examine physician and ss the burial-transit	ical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con Due to (or as a con Due to (or as a con	sequence of): hypological sequence of seq	D-en	n e ir)+,	a.	төэрнасогу аг	i est,		Interval Between Onset and Death
The Collady, F.O. BOX 000 The law requires that the death certiticat the has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown	etal death 3	□Ectopic pr □ Other (sp					23d	Date of delig Month	very Day Year
uires that signed by Id be deta	d by Pr	Part II. Other significant conditions con ANOREXIA	•	resulting in the	underlying o	ause giver	n in Part I.		23e. Did to			the cause of death?
	Completed by	INCONTINE	uce						1 Tes	rmed? 2/1/No	prior to co	opsy findings available ompletion of cause of
ding Phys	tion: To Be	25. Was case referred to medical examiner? 1	ospital: 1 Inpatient : 28a. Date of Injury (Month, Day Yea	2 ER/Outpatie 28b. Time Injury	of 2	Other 28c. Injury Work?	r: 4 □ Nu at	ursing Hol	me 5 X Residence 128d. Describe to	dence 67		ify)
	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp		treet, lactor	y, office			28f. Location (5 City or Tox	Street and N vn, State)	lumber or Ru	ral Route Number,
To the Hospital within 24 hours a To the Funeral I completely tilled	edical C		sician: To the best of my ner: On the basis of exam and manner stated.									
To the within 2 To the complet	W	29b. Signature and title of certifier	, Reill	ym.	0 29	License		14			igned (Month	Z004
		30. Nagrand address of person who co	M.D., 801	116m 23a) (Type Toll Hot	use D-	-1, F	rede	rick,	, Maryla	and 21	L 7 01	
Regi	State	31. Date filed (Month, Day, Year) JAN 2 2 20	32. Régistrar's S	ignature	Land.			,				

Physician Connacio Embolasado Emperado Morno ouy year 1907 2004 4c County of Death 2004 4c County of Death 2004 4c County of Death 2004 4c County of Death 2004 4c County of Death 2004 4c County of Death 2004				For State Registrar	State of Marylar		artment of F rtificate of		Mental H	ygien Reg. N	1 1	04	0180	-
And Control Co		Dhusisi									av	Year	3. Time of Death	_
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College (1-4cr 5+) The Do NOT is a retired) College (1-4cr 5+) Due to (or as a consequence of)		a-f et	ctor	Maryland Prince G	eorge's	Clint	on						1 □ Yes 2 □ N	0
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College (1-4cr 5+) The Do NOT is a retired) College (1-4cr 5+) Due to (or as a consequence of)	036	urs after dea el', or Items Exer, ir et ma	δ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give				Specify Yes or Note Rican, etc.)	lo-	Blac	k, White, e	etc.	
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Society of heart failure. List only one cause on each line. Physician Medical Examiner	m	80 E # 8		St. 9. Soth	M00542	6	633 Old <i>I</i>	Alexandr:						
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25. Was case referred to medical examiner? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 28. Date of Injury (Month, Day Year) 28. Dat	s, P	quires that on signed b uld be dela	by				nderlying cause giv	ren in Part I.						n
The street of th	I Reco		Complet						aut per	opsy formed?	Pa	rior to com leath?	ipletion of cause of	9
The street of th	Vita	ician: certific ector,	Be	examiner?	Hospital: A.F.		Oth		ath (Check only	one)				
O TO TO TOWN, State) 2 Accident investigation M 1 Yes 2 No 2 Accident 3 Suicide 4 Homicide 4 Ho	of	Phys this ral di	H 1		1 npalient 2L	1	3 DOA	4 Nursing I	1					_
S THE STATE OF STATE	ion	nding ath. r: After e fune	ation	1 Natural 5 ☐ Pending					200. 2000100	, now inje	ary occurr	90		
2940	Divis	tal or Atta s after ded al Directo ed in by th	Certifica	d-4	286. Place of injury - At r	nome, farm, str ify)	eet, factory, office		28f. Location City or Te	(Street a	nd Numbe e)	er or Rural	Route Number,	
29a. Certifier Check only 29a. Certifier (Check only Additional coursed at the time, date and place, and due to the cause(s) and manner as stated. Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		ns Hospi n 24 hour ne Funer detely fills		(Check only 2 Medical Exam	niner: On the basis of examina	owledge, death ation and/or inv	occurred at the tirvestigation, in my o	ne, date and place pinion, death occ	e, and due to the urred at the time	e cause(s , date an	s) and mai d place, a	nner as sta	ited. the cause(s)	
Fig. 6		To the To the Comp	Ž	29b. Signature and title of certifier	8.1-						-		Pay, Year)	_
D46478 1.12-04				•	Tors		DL	16478		(-	12-	40		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUPER Contest MD 7501 Surratts Rd. Clinton-MD207	4	315		1	1 . 1	to all to an	Print) Scina	ratti	Let. 1	-lev	171	n-nn	1720737	
State Registrar 31. Date filed (Month, Day, Year) 5 2004 32. Registrar's Signature, JAN 1 5 2004	-	Sta	- 2				locates					1 1 0	.,	-

Emperado, concado

			For State Registrar	State o	f Maryla	ind / Depa	artment of rtificate o				giene	04	01807
			1. Decedent's Name (First, Midd.	(e, Last)						2. Date of De Month		V	3. Time of Death
	Physici /Medio		Mary	Louise		Emmert-	Ruleman			Janua	ry 9, 20	004^{Pear}	1:10PM M
1	Examir		4a. Facility Name (If not institutio	n, give street and nu	mber)		4b. City, Towr	n, or Location	of Death		4c. County	of Death	
н			Washington A	dventist	Hospit	al	Takom	a Park	2		Montgo	omer	7
	Funeral		5. Social Security Number	6. Sex		s. last birthday)	If Under 1 Ye		Min.	8. Date of Bin (Month, Da	th Vosel	9. Birth	place (State or Foreign ntry)
	Director		577-20-6442	1 □ M 2X F	81	Yrs.	Months Day	ys Hours	Min.	Oct. 1	1,1922	Was	shington DC
	P .		Usual Residence of Decedent				<u> </u>						
	nylar	_	10a. State 10b. County		10c. (City, Town or Lo	cation						10d. Inside City Limits
	Ma Ma	cto	Maryland Prince	George's		Coll	ege Par	k					1 ☐ Yes 2 X No
	th th	Director	10e. Street and Number				10f. Zip Code	е			10g. Citizen of V	What Cou	ntry?
	hours after death with the Maryland tural', or Items 23e or 28e-f ehow al Examiner must be notified at		5021 Niagr	a Road			2	0740			U.S.A	A.	
	dea	Funerai	11. Marital Status	12. Was Dec Armed Fo	edent Ever in	U.S. 13.	Was Decedent of If Yes, specify C	of Hispanic C	rigin? (Sp	ecify Yes or No	- 14. Rac	e - Ameri ck, White	can Indian,
ဖွ	or Ite		1 ☐ Never Married 2 💢 Mar		2 X □ ₹ \0		1 □ Yes 2/□ N			1110411, 010.)			hite
8	ours	d by	3 ☐ Widowed 4 ☐ Divorced	Year or D	ates:		10.69 \$4.	чо эрвскі	y. 		Specify	y:	ante
21215-0036	22 8 3	Completed		it's Education st grade completed)		16a. Dece	dent's Usual Occ kind of work do DO NOT use ret	cupation	st of work	ina	16b. Kind of Bi	usiness/lr	ndustry
21	within ene. than "	ğ	Elementary/Secondary (0-12)	College (1-4or 5+)								
7	70 -	Ö	12th			Nu	rse (Adı				WSS		
밀	be filed tal Hyg d othe event,	Be	17. Father's Name (First, Middle,	,	_						. Maiden Suman		
Maryland		2	Dennis Jame		phy						e Weeder		
<u>a</u>	d 2 should th and Mer 7 le marke traumatic		19a. Informant's Name/Relations								er, City or Town,		
	s 1 and f Haalth item 27 other to		Dennis Emmert	(Son)							Marylar		
ore			20a. Method of Disposition ▼M Burial 2 □ Cremation	3 Removal from		. Place of Dispo cemetery, crer	sition (N ame of natory or other p	olace)	Jar	n. 17,	20c. Location -	City or T	own, State
Ĕ	nit. Pagas artment of ortent: If it injury or o	Ш	N Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	Specify)	R	esurrec	tion Cer	netery	200)4	Clinto	on, M	aryland
Baltimore,	parmit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service	Licensee		22	2. Name and Add	dress of Faci	ility Le	ee Fune:	ral Home	e, In	c.
Φ.	20 E 2 9		15kg.50	the Mos	5H2	6	633 Old	Alexa	ndria	a Ferry	Road Cl	into	n, MD20735
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that of	caused the de	ath. Do not ent	er the mode of o	tying, such a	s cardiac	or respiratory ar	rrest,		Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition			Kosec	KUST.C	10/2	mi	ALTO	WJo		Onset and Death
4	/Medical		resulting in death)		(or as a cons		,			-		-	
	Examiner			En	-PK	5 sng	160	RK	2				
	_	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a cons	equence of): 🗸					,, -		
	uted d ansit	Examin	Cause (Disease or injury that initiated events	1 . 4	Kon	DX 10	Westy	100	ello	u.c A	SMI		
oʻ	exec an an rial-tr	Exa	resulting in death) Last	Due to	(or as a conse	equence of):	Mosery			1-	-115		
8760,	death certificate be executed e attending physician and of for use as the burial-transit	edical		d						NIN	M) 8 .		
68	ificat g phy as th	edi											
Вох	eath certific attending pl	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou			1 -				23d. Dat	e of deliv	ery
œ.	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregr	ointh 2 - Fe nant at time of		Ectopic pregnal Other (specify)				Mo	nth	Day Year
0	that the dead by the detached	hys	9 □ Unknown	9□ Unkn	own								
0		by P	Part II. Other significant conditi	ons contributing to d	eath but not re	esulting in the u	nderlying cause	given in Part	:1.	23e. Did to	obaceo use conti	ribute to t	he cause of death?
g	requires ween signi									12	res 2□No	3 ☐ Prot	ably 4 Unknown
Vital Records,	> 10 0	Completed								24a, Was	an 24h V	Nere auto	psy findings available
Re	The law rate has b page 2 sl	를					-			autop	sy	prior to co	mpletion of cause of
a	icien: Th certificate rector, pag		05 116									Yes	2 No
₹		Be	25. Was case referred to medica examiner?	Hospital:				Othor		(Check only o			-
ō	Phys this aldi	2	1 ☑Yes 2 ☐ No 27. Manner of Death	28a. Date		ER/Outpatien 28b. Time of	1 3 DOA	401			dence 6 Other		ý)
	tending leath. for; After the funer	io	1 ZNatural 5 ☐ Pendir	ng (Mon	th, Day Year)	Injury	V	vork? ∐Yes 2[200. 2000100 1	low injury occurr	00	
<u>S</u>	Attending r death. sctor; After by the fune	ical	2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	not be	of lations At	home, farm, str			-	29f Location /S	Stroot and Numb	Ar ar Ou	al Route Number,
Division	P S S	ertification;	4 Homicide determ		ing, etc. (Spec		eet, lactory, offic	ю		City or Tow	vn, State)	er or mura	i noule Number,
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	O	29a. Certifier 1 X Certifyii	a Physician: To the	hast of muck	nourindan dooth		time data a	ed place	and due to the			
	Hos 24 ho Fun Hely	edicai	(Check only 2 Medical one)	ng Physician: To the Examiner: On the b	asis of examination	nation and/or inv	estigation, in m	y opinion, de	ath occurr	ed at the time, o	date and place, a	nner as s and due to	tated. the cause(s)
	thin thin the	Mec	29b. Signature and title of certifie	_		7	29c. Lice	nse number			29d. Date signed	/Month	Dav. Year)
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1	Ri		30. Name and address of person		_	em 23a) (Type, 7600 Car	Print)	enue 7	rakom	a Dark	Marylar	nđ.	
	Vb		31. Date filed (Month, Day, Year)	COLEM 32.8	egistrar's Sign	natur# 4	AULL MV	wide J	Larolli	a rath,	· ···· y ·····		
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			JAN -	-									

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death

	Physician		. Decedent's Name (First, Middle, I								Month	Day	Year	3. Time of Death	
	/Medica		HELEN LOUIS		ED	LER			th Ch. T.	m orlar	Jan.	8, 20	04	5:30 PM	_
	Examine	4	a Fecility Name (If not institution, g												
			Salisbury Rehab Social Security Number 6	and Nursing	Cente	r	If Under	1 Year	Salish If Under 2	oury,	Md.	Wic	omico	o (State or Ecrain	_
	uneral	10	216-09-6124	1□ M 2√xF /. Age	86	Yrs.	Months	Days	Hours	Min	(Month Day	Year) 12,1917	Country	land	á
-	irector	ι	Jsuel Residence of Decedent								1010.00		1.0.2 /	Laria	_
Within 72 hours after death with the Maryland	M 18	1	0a. Stete 10b. County		10c. City, To								10d.	Inside City Limits	
	1	N	Maryland Wicon	nico	Sal	isbu	ıry					Bay Year 8, 2004 4c. Country of Deeth Wi COMICO Birth Day, Year) Per 12,1917 10d. Inside City 10d.	1⊠Yes 2□No	'	
	or 28	5 1	0e. Street end Number				10f. Zip	Code			10		?		
	23a	5	200 Civic Ave					1804							
	si', or tems 23s or 28s-f show Examiner must be notified at the Euneral Director		1. Marital Stetus	12. Was Decedent E Armed Forces?		13. V	Vas Deced Yes, spec	lent of H cify Cuba	lispanic Orig an, Mexican	jin? (Spec , Puerto P	cify Yes or No- Rican, etc.)				
1		Ĺ	1 Never Married 2 Merried	If Yes, Give	0	1	☐ Yes 2	No	Specify:			Specify	whi:	te	
Tire!	A C	o p	3 □XWidowed 4 □ Divorced	Yeer or Dates:	16	a Deced	ent's Usua	1 Occup	ation			I6b Kind of Bu			
	event, the Medical		15. Decedent's (Specify only highest of	rede completed)		(Give I	kind of wor	rk done (during most	of workin	ig .	100. 111110 01 00	3311030111030	,	
then.	3	Ē	Elementary/Secondary (0-12)	College (1-4or 5+	+) N		gement					Reta	il		
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antal ked c	To B	Ď	Edward Coffin						Ca	rrie	Twigg				
DU NO	Tames -		19a. Informant's Name/Relationship	(Type, Print)	19									ode)	
27 te	1		Paul Spide/son			305	Warre	en P	lace,	Wash	hington,	NC 27	889		
I Hera	t t	2	Oa. Method of Disposition		20b. Place cemet	of Dispos	sition (Nan	ne of ther plac	ce)	İ	Date 2	20c. Location -	City or Town	, State	
tmant o	<u>p</u>		1 ☑ Buria! 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spe						etery	1,	/12/04	Pocomo	ke Cit	y, MD	
Part	/ injury ce.		21. Signature of Funeral Se vice Lic	ensee		22.	Name an	d Addre	ss of Facility	n Fur	neral Ho	me			
S.E.	§ 8	1	Mark 0	Do.	4.1	ì	.03 L	inde	n Ave	., Po	ocomoke	City,	MD 218	51	
		1	23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused in	the death. Do	not ente	er the mod	e of dyin	ng, such as	cardiac or	r respiratory arre	st,	i A	pproximate terval Between	
vs	ician		Shock, or near failure. List on	ly one cause on each line	0.								Ö	nset and Death	
Лed	lical		Immediate Ceuse (Final disease or condition	CIMA	octores	(D)	card	MA	mat	Time			1 (44)	Kuluan	
amir			resulting in death)	a. Jr	Due to (or as	a conseq	uence of):	1017	14001	7					
- /	<u> </u>	5		• b									i		
attanding physician and for use as the budal-transit	100	Xari	Sequentially list conditions,		Due to (or es	e consequ	uence of):								
iclan	buna Fi		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events	c									i		_
phys	Tor usa as the bunal-transit	5	resulting in death) Last	D	Due to (or as a	a consequ	uence of):						1		
ding	Saa	2		d											_
attar	fort	2 .	Part II. Other significant conditions	and the stine to death her	t not constitut	in the un	adorluing o	auco ak	on in Part I	-	23h Did to	hacco use co	ntribute to th	e cause of death	
y the		2 '			it not resulting	in the ur	iderlying G	ause giv	on arranci.						
been signed by the should be datached	2		Alzheiner's	lementa								,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,	
n sign	<u>د</u> و	2											24b. Were	autopsy findings	
eed s	Sho								1		perion	.00:	comp	letion of cause	
a has	į										1 TY	s 21/NU	101	′es 2□No	
ificat tor, p	Be Completed by Dhye	ב כ	25. Was case referred to medical						26. Place	of Death	(Check only on				-
within 24 hours aftar death. To the Funeral Director: Aftar this cartificata has complataly filled in by the funaral director, page 2	T C	0	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatien	nt 2 ER/0	Outpatien	t 3 DC	Oth Oth		-			er (Specify)		
ar thi			27. Manner of Death	28a. Date of Injury (Month, Day	y Year) 28b	. Time of Injury	2	8c. Injur	y at rk?	2	8d. Describe ho	w injury occur	red		
ath. rr: Aft			1 Naturel 5 Pending investigation	ion		,	М		Yes 2 □ I	No					
affar daath Director: /	led in by the funare		3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	t be ed 28e. Place of Inju- building, etc.	ry - At home, . (Specify)	farm, stre	eet, factory	y, office		2			er or Rural F	loute Number,	
Is aff	ع و		,												_
within 24 hours To the Funeral	ien,		(Check only 2 Medical Ex	aminer: On the besis of	exemination a	ge, death and/or inv	occurred estigation	at the tir , in my c	me, date and pinion, dea	d place, a th occurre	and due to the ca and at the time, da	USA 14. Race - American Indian, Black, White, etc. Specify: white 16b. Kind of Business/Industry Retail Idle, Maiden Surname) 19 20c. Location - City or Town, State, Zip Code) 20c. Location - City or Town, State POCOMOKE City, MI Home Ske City, MD 21051 Ty arrest, Approximate Interval Betwonset and Done of Constant Conset and Done of Conset and Done of Conset Completion of Conset	ed. ie cause(s)		
the F	in plat		one) 29b. Signature end title of certifier	and manner stat	ted.		200	c. Licens	e number		20	d. Date sinne	d (Month De	v. Yeer)	_
¥ 0	8		290. Signature end title of certifler						280	7	2	1/9/	04	,. · · · · · · /	
			Collette					VS	003	<u> </u>		(1 (1			
1	7	:	30. Name and eddress of person wt	o completed cause of de	eath (Item 23e) (Type, I		a	Divi	. a	ah a	0-1:-	bure -	M& 21004	1
1		4	31. Dete filed (Month, Day, Year)	no militare	er's Signature				บะงาร	ion :	st.Suite	e,Salls	oury,	MG.21804	ŀ
F	State Registrai		JAN 12	2004 A Segue	ers Signature	So	ade	;							
						1 1									

ORIGINAL

DHMH 16 Rev 6/95

			1 - For Amend Item 24 Registrar	State of M 4a per verb.,G			artment of I				004	01809
	Physic	ian	Decedent's Name (First, Middle	_ '					2. Date of D	eath Day	Year	3. Time of Death
1	/Medi		Beulah	J.		end			OI	20	100	12:25 PM
	Examir	ner	4a. Facility Name (If not institution,	4 2 4	. 1		4b. City, Town, o	or Location of De	ath	1 4	ounty of Deat	
			socred Her	nt Hosp			Com	oer Cu	1d	1	tilego	
	Funeral Director		5. Social Security Number 215-36-7686		зе (<i>in yr</i> s. <i>i</i> . 66	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Mi	n. 8. Date of 8	irth 5, 193	7 9. Birti	nplace (State or Foreign
			Usual Residence of Decedent						- Juli 1	0, 100		IVID
	yland		10a. State 10b. County MD Alleg	O D14	10c. City	, Town or Lo	cation					10d. Inside City Limits
	Maria S	ţō	MD Alleg	arry		Cumb	erland					Yes 2 □ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or items 23e or 28e-f show, myoriant: If item 27 is marked other then "neturel", or items 23e or 28e-f show, my injury or other traumatic event, in Medical Exams are must be incuffed at 2008.	Completed by Funeral Director	10e. Street and Number 526 Necessity S	treet			10f. Zip Code	21502			en of What Co USA	untry?
	dea	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13.1	Was Decedent of h	Hispanic Origin?	(Specify Yes or N	0- 14	. Race - Ame	ncan Indian,
9	after or It	3	1 ☐ Never Married 2 ☐ Marrie				1 ☐ Yes 2 ☐ No		ano rucan, etc.)	1	Black, White	
21215-0036	72 hours after death w "naturel", or Items 23a	d b	3 Widowed 4 □ Divorced	Year or Dates:	·						pecify:whit	e e
7	"nat	ete	15. Decedent' (Specify only highest			16a. Deced (Give	dent's Usual Occup kind of work done DO NOT use retire	oation during most of w	rorking	16b. Kind	of Business/I	ndustry
121	within ane. then	m	Elementary/Secondary (0-12)	College (1-4or	5+)	nomer		d)		own h	ome	
d 2	filed with Hygiene other the	ပိ	17. Father's Name (First, Middle, L	ast)	I			18 Mother's N	ame (First, Middl	1		
Maryland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Me	To Be	Jacob Mullena	X				Lenora	Evans	Mullen	ax	
	s 1 and 2 st f Health and item 27 is r other traur		19a Joformant's Name/Relationsh Clifford Friend	son	201 51			Heights				MD ⁽²⁾ 21532
Baltimore,	Pages 1 nent of H ant: If ite ury or otl		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (Sp		Gleñ	ace of Dispo metery, cren dale Ce	sition (Name of natory or other plac metery	ce)	Date 1/24/2004		ition - City or 1 stone	own, State
Balt	permit. Page Department o Important: If sny injury or once.		21. Signature of Funeral Service L	Lember 1	ı î	22	Nar Scarpell 108 Virg		lome, PA le: Cumbe	land. M	ID 21502	
	Prysician /Medical Examiner	Examiner		Approximate Interval Between Onset an Death								
.O. Box 68760,	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medical Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d	of pregnan	ncy death 3	Ectopic pregnancy Other (specify)	,		230	d. Date of deliv	rery Day Year
S, D	s that ned b	by Pr	Part II. Other significant condition	s contributing to death b	ut not resul	lting in the un	iderlying cause giv	en in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
r ds	quires n sign	d b	CARadmy	portry					10	Yes 2	No 3□Pro	bably 4 Unknown
Record	w requir	iete	Doras	Post no					24a. Was	an	24h Were aut	opsy findings available
al Re		e Completed	25. Was case referred to medical	lenn de	SEPTE	>			auto perf 1 ☐ Yes	psy ormed? 2 XNo	prior to co death? 1 Yes	empletion of cause of
Vital		o B	examiner?	Hospital: 1 Inpatie	- 205	R/Outpatient	2 DOA Oth	1 - 2 - 2 - 2 - 2 - 2 - 2 - 2	eath (Check only			
o		F 7	27. Manner of Death	28a. Date of Injur	ry :	28b. Time of	28c. Injun Worl	4 🗆 Nursing	Home 5 Res			fy)
O	nding I th. : After s funer	tio	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		y Year)	Injury		k? Yes 2∐No				
Division	Hospital or Attending 14 hours after death. Funeral Director: Afte tely filled in by the fune	Certification;	3 Suicide 6 Could no 4 Homicide determin				et, factory, office		28I. Location (City or To	Street and f wn, State)	lumber or Run	al Route Number,
	To the Hospital or Atti within 24 hours after de To the Funeral Direct completely filled in by th	Medical C	29a. Certifier (Check only one) Certifying 2 Medical E	Physician: To the best of xaminer: On the basis of and manner sta	of my know examination	rledge, death on and/or inv	occurred at the tin estigation, in my o	ne, date and plac pinion, death occ	e, and due to the curred at the time,	cause(s) an date and pl	d manner as s ace, and due t	stated. o the cause(s)
	To the vithin 2 To the complet	Me	29b. Signature and title of certifier	(\M.)	-~		29c. License	e number		29d. Date s	igned (Month,	Day, Year)
)	/		+ Kor	or Com	5)		De	31875		-		
	5		30. Name and address of person w	no completed cause of de	eath (Item	23a) (Tvne s	Print)	3010		JI 3 OI	,-J~	~-~7
148	Sta	te	Dr. Rober F 31. Date liled (Month, Day, Year)	Welk 32, Registra	900	Set		ve, Ci	emb.	4d.	2150	2004
	Registr		JAN 2 3	2004	المنداب المسادة	· Lan	sell i					

			1 - State Registrar	State of Man			ent of H			R	eg. No.	004	
	Physici /Medi		1. Decedent's Name (First, Middle, L	ast)	G	mid	0			. Date of Deal Month	Day	Year 2004	3. Time of Death
*	Examir Funeral		4a. Facility Name (If not institution, g	SYNOHOO	nyrs. last birthday	If Uno	ler 1 Year	Location of De	RE	. Date of Birth		9. Birthp	place (State or Foreign
	Director		219 48 6650 Usual Residence of Decedent	1\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	57 Yrs.	Month	s Days	Hours M	lin.	Date of Birth (Month, Day) Oct 24	, 194	6 Wes	t Virginia
	Maryland a-f show	ctor	PA Cumbe		Oc. City, Town or L	ocation Vewbu	ırg					1	0d. Inside City Limits 1 □ Yes 2 □ No
	h with the	ai Dire	10e. Street and Number 23 Peebles Roa	d		10f.	Zip Code 17240)		1	_	of What Cour ed Sta	
036	be filed within 72 hours after death with the Maryland lat Hygiene. d other than "netural", or Items 23e or 28a-f show event, the Medical Exarting mant be regulied at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1.	or in U.S. 13.	If Yes, s	cedent of Hi becify Cuba	ispanic Origin? n, Mexican, Pu Specify:	(Specification (Speci	iy Yes or No- can, etc.)	1	Race - Americ Black, White, ecify: Wh	
Maryland 21215-0036	filed within 72 ho Hygiene. ther then "netur ont, I're Medical	ompieted	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)		(Give	kind of DO NOT	sual Occupa work done of use retired	luring most of s	working			erical	dustry
/land /	9 70 5	To Be C	17. Father's Name (First, Middle, Last Ettore Guido	st)				18. Mother's N		First, Middle, I	Maiden Sun	пате)	
	ages 1 and 2 should b nt of Health and Ment t: If item 27 is marked y or other traumatic e			(Wife)	23	Peel	les F	Road, No	ewbu	ırg, PA	1724	0	
Baltimore,	permit. Pages 1 Department of H Important: If ites any injury or ott		20a. Method of Disposition 1 XX urial 2 Cremation 3 4 Donation 5 Other (Spec	ify)	20b. Place of Disp cemetery, cre Trinity	Memo	orial	Garden	S		Waldo	on-City or To	ryland
Ba	Depar Impor any ir		21. Signature of Funeral Service Lic	h Moor								-	6633 01d and 20735
	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	mplications that caused the yone cause on each line. a. Crays Ne	ignitive s			g, such as card	liac or r	espirato <i>r</i> y arre	est,		Approximate Interval Between Onset and Death
3/60,	death certificate be executed e attending physician and d for use as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infilted events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):										
O. Box 6	ath certific attending p or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of particle in the second seco	Fetal death 3	⊒Ectopic ⊒ Other	pregnancy (specify)			5 5*//-	23d.	Date of delive Month	ory Day Year
1	es that gned b	þ	Part II. Other significant conditions	contributing to death but n	ot resulting in the u	underlying	cause give	en in Part I.		23e. Did tob	1.0		ae cause of death?
Hecords,	The ate ha	Completed							-	24a. Was ai autops perform	y ned?	prior to cor death?	psy findings available πpletion of cause of 2. No.
Vital	ician: certific rector,	o Be	25. Was case referred to medical examiner?	Hospital:			Othe	26. Place of D					
on of	ing After une	H	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	1 Minpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatie 28b. Time o Injury		28c. Injury Work	4 - 140131110		5 Reside			/)
DIVISION	2 2 2 6	Certification;	3 Suicide 6 Could not 4 Homicide determine	be 280 Place of Injury	- At home, farm, st Specify)	reet, fact	ory, office		28f	. Location (St. City or Town		ımber or Rura	I Route Number,
	To the Hospitel c	Medicai (Physician: To the best of maminer: On the basis of examiner stated									
	To the within to the comp	X	29b. Signature and title of certifier Chathlin C. W.	Mans		2	9c. License	number 5 - 000		25	och va r	gned (Month, I	Day, Year)
1	BL		30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print)	Re spe	et Roll	Him	ore, the	2/2	87-9	106
7	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	freu	W	, ,		, -			

			1 - For State Registrar	State of Maryla		irtment of Healt tificate of Dea			ene	004	01811
			1. Decedent's Name (First, Middle, Last)					2. Date of Death		V	3. Time of Death
	Physici /Medi		EMIL	Ε.	GUST	AFSON		DNUDRY	Day 6	2004	0645 M
	Examir		4a. Fecility Name (If not institution, give			4b. City, Town, or Locat	tion of Death			unty of Death	
			PENINSULA REBIONA		CENTER	SAL	115641	1			MICO
V.	Funeral		5. Social Security Number 6. Sex 470-22-0495	7. Age (In yrs	s. last birthday) 79 Yrs.	If Under 1 Year If Un Months Days Hou	nder 24 Hrs. urs Min.	Date of Birth (Month, Day,	Year)	9. Birthpl Count	ace (State or Foreign try)
rois	Director		Usuel Residence of Decedent		79 Hs.			3-19-	24		MN
	land ow		10a. State 10b. County	10c. (City, Town or Lo	cation				10	Od. Inside City Limits
	Mary Fied	ţ	Md. Worcest	er Be	erlin						Yes 2□No
	r 28e	lrec	10e. Street and Number			10f. Zip Code		10	g. Citizer	n of What Coun	try?
	h witi	alD	14 Fishermans I	rive		21811			U.S	. A .	
	hours after death with the Maryland tural', or Items 23a or 28e-f show at Exa. itrust be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. V	Vas Decedent of Hispanio Yes, specify Cuban, Mex	Origin? (Spe	cify Yes or No-	14.	Race - America Black, White, 6	
9	or It		1 Never Married 2 Married	1 Yes 2 No		Yes 24 No Spe		noan, oto.,	8,		
Ö	ural',	d by	3 Widowed 4 Divorced	Year or Dates: UV	WIL					WILL	
21215-0036	n 72 nat	Completed	15. Decedent's Educ (Specify only highest grade		(Give	ent's Usual Occupation kind of work done during (OO NDT use retired)	most of worki	ng 1	8b. Kind	of Business/Ind	ustry
12	filed within 72 Hygiene. other then "na ent, It a Medic	mc	Elementary/Secondary (0-12)	College (1-4or 5+)		Clergyman			R	eligio	n
Ö	Hygir other ent, I	Be C	17. Father's Name (First, Middle, Last)				lother's Name	(First, Middle, N			
Maryland	should be filed within 72 hours after death with the Marylar of Mental Hygiene. marked other than "natural", or Items 23a or 28e-1 show marked other than "natural", or Items 23a or 28e-1 show marice event, Ite Medical Exa.	To B	Oscar Otto Gus	tafson		Н	ildur	Lindbe	erq		
a Z	should and Men s marke umatic	_	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailin	g Address (Street and Nu	ım <i>b</i> er or Rura	l Route Number,	City or To	own, State, Zip	Code)
	as 1 and 2 should to Health and Ment if item 27 is marked rother traumatic a		Charlotte W. Gu	ıstafson	14 I	Fishermans	Drive	e Berli	n,	Md. 21	811
altimore,	of He of He fiter		20a. Method of Disposition 1 ☐ Burial 2 Ø Cremation 3 ☐ R.		Place of Dispos	sition (Name of patery or other place)	D	ate 2	oc. Locat	tion - City or To	wn, Stete
Ĕ	Pages nent of snt: If it ury or o		*4 □ Donation 5 □ Other (Specify)	Samovai from State		ry Crem.	1-7	-04	Sa1	isbury	, MD.
a	permit. Pages 1 Department of H Importent: If ite any injury or ott		21. Signature of Furieral Service Lidense	ө	22	Name and Address of F	acility				
m	90 = 99		Jemes aller			Jiirich Fu				in, Md	. 21811
N.			23a. Part. Enter the disease, or complication shock, or heart failure. List only on	ations that caused the dea e cause on each line.	ath. Do not ente	er the mode of dying, such	h as cardiac o	r respiratory arre	st,		Approximate Interval Between
. 6	Physician		Immediate Cause (Final disease or condition	ATHERO.	SCLE	ROTIC CA	RDIOVA	SCULAR	L D	1SEASIE	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse							.,
- 14	LAdillillei	_	Sequentially list conditions b	DIABET		1 ELLITU	5				
	ed isit	Examine	Sequentially list nonditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	. ,						
	and and II-tran	xan	that initiated events resulting in death) Last	PNEUM Due to (or as a conse							
8/60	cate be executed physician and the burial-transit		1	0.00 10 (0. 20 2 00.100	74201100 017.						
28	certificate be executed nding physician and use as the burial-transit	edical	d								
XOX	leath certific attending p	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome of pregr					230	I. Date of delive	rv
ň	death e atten	icla	in the past 12 months?	1□Live birth 2□Fel 4□Pregnant at time of		Ectopic pregnancy Other (specify)					Day Year
5	t the by the ache	hys	9 Unknown	9□ Unknown							
ري ح	w requires that the de been signed by the should be detached	y P	Part II. Other significant conditions con	ributing to death but not re	sulting in the un	derlying cause given in P	art I.	23e. Did tob	acco use	contribute to the	e cause of death?
ğ	an sig	edt		<u></u>				1 ☐ Ye	s 2 🗆 N	lo 3∏Proba	ably 4 🖾 Onknown
ecords,	law re as be	plet						24a. Was an		4b. Were autop	sy findings available
Y	sicien: The law certilicate has b lirector, page 2 s	Completed by						autopsy perform 1 Yes 2	ed?	death?	npletion of cause of 2□ No
VITAL	ysicien: is certifica director, l	Bec	25. Was case referred to medical examiner?			26. P	lace of Death	(Check only one			
> 		2	1 □ Yes 2 No	ospital: 1 Inpatient 2	☐ ER/Outpatient	3 DOA Other: 4	Nursing Hon	ne 5 Resider	nce 6	Other (Specify)
	ding Phy h. After thi funeral o	on:	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	2	8d. Describe ho	w injury o	ccurred	
DIVISION	eath. or; A	Certification;	2 Accident investigation			M 1 Tes 2	2 No				
\geq	or Att	E	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, stre cify)	et, factory, office	2	8f. Location (Str. City or Town,	eet and N State)	lumber or Aural	Route Number,
ב	pitet		20a Carifica								
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	edical	29a. Certifier (Check only one) 1 Certifying Phys. 2 Medical Examin	cian: To the best of my kn er: On the basis of examin	vation and/ar inv	antination in mu anining	don'th annuers	al at the time and			the equation
	o the ithin o the omple	Mec	29b. Signature and title of certifier	and manner stated.		29c. License numb	oer	29	d. Date s	igned (Month, L	Dav. Year)
	F 3 F 8			7.)		1579	50	23	1/6	1200	1.
			30. Name and address of person who cor	noleted cause of dooth the	m 22a) /T 5	Print)	700		1	/	7
H	.5+1		Babulal Das	and manner stated. 1) Inpleted cause of death (Ite 106 Mul for 32. Registrar's Sign	111 23a) (Type, F	#504B	Salis	burn 1	40	2/80	04
	Stat	e	31. Date filed (Month, Day, Year)	32. Pegistrar's Sign	nature	N n		/		,	
	Registra		IAN 0 8 20	14 Matings	15 QU	BASIL!					

470-22-0445

Gustarson

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Idi		ı	1- For Unpend Item #23a,27,28a i per me G828 2/2/04	Mental Hy	giene	: 01612
			Decedent's Name (First, Middle, Last)	2. Date of De.	ath	3. Time of Death
	Physici /Medic		Amy Elizabeth Gallion	Januar Januar	Day Yeer	4:10 AM
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dear		4c. County of Dee	
			Upper Chesapeake Medical Center Bel Air		Harfon	4
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min	8. Date of Bird	th o p:	thplace (State or Foreign ountry)
	Director		217-02-1627 21 Yrs.	Dec. 27	, 1982 Mai	ryland
)	pus M		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Aaryli aho	ច				1 ☐ Yes XX No
	28a-	ect	Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code		10g. Citizen of Whet C	ountry?
	with Ba or	<u></u>	1405 Landis Circle 21015		USA	
	72 hours after death with the Maryland natural', or Items 23a or 28a-f ahow iteal Examiner must be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (5	Specify Yes or No		
ယ	or Iter		1 🔁 Never Married 2 🗌 Marned 1 🗌 Yes 2 🌠 No	rto Rican, etc.)	Black, Whi	te, etc.
Ö	ours a	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		Specify: V	√hite
5-0036	72 ho	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of wo	orkina	16b. Kind of Business	/Industry
7	within ene. then	npi	Elementary/Secondary (0-12) College (1-4or 5+)			_
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and	be fi	Be		me (First, Middle). 1y Anne 1	Maiden Sumame)	
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Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylan is Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f ahow other traumatic avent, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print) Kimberly A. Gallion / Mother 1405 Landis Circle,			Zip Code)
	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		20a Mathod of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City or	Town, Stete
Baltimore,	ages ant of t: If it		**DSBurial 2 Cremation 3 Removal from State Cemetery, crematory or other place) 4 Donation 5 Other (Specify) Bel Air Memorial Grans 1-	20-04	Bel Air, Ma	bre lyne
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			23a. Part1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause or each line.			Approximate Interval Between
L.	Physician		Immediate Cause (Final			Onset and Death
	/Medical		disease or condition resulting in death) a. Acute alcohol intoxication Due to (or as a consequence of):			
	Examiner		Sequentially list conditions			
	п ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa Uiseasa or injury			
	acute	Examiner	triat initiated events			
Ő,	tate be executed obysician and the burial-transit	Ě	resulting in death) Last Due to (or as a consequence of):			
8760,	death certificate be executed e attending physician and nd for use as the burial-transit	Physician/Medical	d			
9 ×	leath certifica attending ph I for use as th	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			
Вох	attendation	ian	250. Was decedent pregnam 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of de Month	livery Day Year
0	the de	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			
۵.	law requires that the de as been signed by the a 2 should be detached f	F.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Records,	w requires to been signer should be a	d by		1 🗆 Y	′es 2 □ No 3 □ P:	robabiy 4 🗍 Unknown
00	w req beer shou	Completed		24a. Was	an 24h Were a	utopsy findings available
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Ē	Physician: The this certificate har all director, page	To B	examiner?	ath (Check only o	ne) lence 6 □Other (Spe	a.6.1
o	y Phys er this eral dil	H	27 Namer of Dooth 29a Date of Joines 20b Time of 20a January		low injury occurred	Cny)
Ö	Attending Probable and Control of the funering the function of th	atio	1 Natural 5 Pending Fulf 1, Day Year) 2 Accident investigation 114, 04 Unknown Work? 1 Yes 2 No	Unknown	ı	
Division	Attendi er death. actor: A by the fu	ific	Suicide 5 Suicide 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (S	Street and Number or R	ural Route Number,
	s afte al Dir	Certification:	4 ☐ Homicide building, etc. (Specify) Unknown	Unkno	200000	
	hour hour uner	edical	29a. Certifier (Ch) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place 2/3 edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2/3 edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2/3 edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2/3 edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2/3 edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2/3 edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date 2/3 edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date 2/3 edical Examiner: On the basis of examination and 2/3 edical Examiner: On the basis of examination and 2/3 edical Examiner: On the basis of examination and 2/3 edical Examiner: On the basis of examination and 2/3 edical Examiner: On the basis of examination 2/3 edical Examiner: On the basis of examination 2/3 edical Examiner: On the basis of examination 2/3 edical Examiner: On the basis of examination 2/3 edical Examiner: On the basis of examination 2/3 edical Examiner: On the basis of examination 2/3 edical Examiner: On the basis of examination 2/3 edical Examiner: On the basis of examination 2/3 edical Examiner: On the basis of examination 2/3 edical Examiner: On the basis of examination 2/3 edical Examiner: On the basis of examination 2/3 edical Examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of exami	e, and due to the o	ause(s) and manner as	s stated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medi	one and mainter stated			
	To To con	2	29b. Signature and fittle of certifier 29c. License number O • C • M • I		29d. Date signed <i>(Mont</i> January 15 ,	
			(Creene			
	12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Dolt-i	a Massala - 3	21201
	Sta	to	31. Date filed (Month, Day, Year) 32. Registrar's Signature	DOTT L'ILIOILE	e, Maryland	21201
	318	te ar	1AH 2 3 2000 Men 2 Amark 9			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** SICOA M Helen Marquerite Dakeru 4a. Facility Name (If not) Institution, give street and number) Baker Williams 2104 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical 7. Age (In yrs. last birthday) Upper Chesapeake 5.9bcial Security Number 6 HarFord If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1□M 2XF 492-50-919 Usual Residence of Decedent -50-9190 ARKansas Director 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County rthan "natural", or Itams 23a or 28e-f shov the Medical Examiner must be notified at 1 Yes 2 □ No Director Maryland Har Ford berdeer 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 21001 aker Completed by Funeral 1261 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: American Indian, Black White etc. 1 Never Married Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: Specify: 3 Widowed 4 Divorced "natural" 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Com Secretary Mevina . Pages 1 and 2 should be filed v tment of Health and Mental Hygie tent: If item 27 Is marked other t jury or other traumatic evant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnar (19) Be IMPE aKer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ို arence 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health ar
Importent: If item 27 Is
any injury or other trau 2 c. Location City or Town, State Yus band 20a. Method of Disposition Marry obes timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State emetery: 1-13-2004 22 Name and Address of active 21. Signature of Funeral Service Licensee Funeral Home Aberdeen Street 2100 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastati Breast Cane Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Univerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and I-transit Due to (or as a consequence of): the attending physician a hed for use as the burial: Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? this certificate 1 ☐ Yes 2 No of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 1 atient 4 Nursing Home 5 Residence 6 Other (Specify) ပ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

may you

602 S. Atwood Rd, * 208 Bel Aci, MD Vincent A. Giminaro, Do. 32. Reginar's Signature 31. Date filed (Month, Day Year) lesen & Sperk

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🖅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

MB H0054439

29d. Date signed (Month, Day, Year)

January 10, 2004

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Yeer **Physician** Noel Kolpack 2:58PMM Stanley January 11, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince George's 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 15 | Yrs | Months Days | Hours | Min. 8. Date of Birth 9. Birthplece (State or Foreign Jan: 11,1949 Washington DC 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 ☑ M 2 ☐ F 55 579-58-7995 Director Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√2 No Maryland Prince George's Clinton Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? il Hygiene. other than "natural", or Itams 23a or vent, the Medical Expriner must be. 6206 Buckler Road 20735 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Maritat Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th N/A Disabled N/A Disabled permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any linity or other traumatic svent 90Rg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thelma Lucas Stanley Kolpack Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6206 Buckler Road Clinton, Maryland 20735 Mary Kolpack (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition January 17, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 2004 Resurrection Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Lisensee Lee Funeral Home, Inc. Alis 10015 6633 Old Alexandria Ferry Road Clinton, MD20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Un Know /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, bading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown Neumones Completed 24b. Were autopsy findings available prior to completion of cause of death? performed' 1 ☐ Yes 2 ☐ No 1 Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA : After the 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 104 54 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Silver Spring MD Zegoz 9801 Gearge Ave Suit 3 32. Registrar's Signature 31. Date filed (Month, Day, Year) JAN 15 2004 State Registrar

		1	For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment rtificate			nd M		enez n n l.	01815
	Dhooisi		1. Decedent's Name (First, Middle, Las	t)						2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		Charles			enney				Januar	7 10,2004	12:15PM
7	Examir	er	4a. Facility Neme (If not institution, give					Location of			4c. County of Death	
			Charlotte Hall V 5. Social Security Number 6. Se		Home ge (In yrs. last birthday)	Cha If Under		te Ha		8. Date of Birth	St. Mary	
L	Funeral Director				83 Yrs.	Months	Days	Hours	Min.	(Month, Day, August		pplace (Stete or Foreign intry)
No.	D		Usual Residence of Decedent							August .	4.3 , 1.3 EU VVE	est Virginia
	arylar show	ايا	10a. State 10b. County Maryland Anne Arur	.a.1	10c. City, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he M	ecto	10e. Street and Number	raer	Lothia	10f. Zip	Code			10	g. Citizen of What Co	
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	be filed within 72 hours after death with the Marylan hal Hygiene. Id other than "natural", or items 23s or 28s-f show of other than "natural", or items 23s or 28s-f show avent, it a Medical Examinar must be notified at	BeC	17. Father's Name (First, Middle, Last)		<u></u>		2	18. Mother	r's Name	(First, Middle, M		100
ylai	should be nd Menta marked imatic av	To To	William Kenr					Haz			sser	
Maryland	2 9 3 9		19a. Informant's Name/Relationship (7								City or Town, State, Z	
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Baltimore,	permit. Pages Department of I Important: If ite any injury or of		21. Signature of Edneral Sancice, Licen		2 5 3	2. Name an 6633	d Addres	s of Facility Alex	Lee	Funeral	Home, Inc Road Clir	2.
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5	B151		30. Name and address of person who		death (Item 23a) (Type		B. K	arnaksi	hi,	MD H.	1-20646	
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	Regist	rar	JAN I 5	2004 🎉	eve It	Correll	,					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 6:06A M Kilby Mary Louise /Medical January 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Civista Medical Center LaPlata Charles If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours 1 □ M 2 🔀 F Yrs. Director 579-38-0132 Aug. 10,1930 West Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or Items 23a or 28a-f show Examinat must be notified at 1 ☐ Yes 2 No Maryland Charles Pomfret Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20675 - 23a r U.S.A. 9415 Marshall Corner Road death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2XXIVo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White by ar than "natural", the Medical Evo 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 9008. Be Charles Gaertner Lorraine Hawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Kilby (Husband) P.O. Box 187 Pomfret, Maryland 20675 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 12, 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 2004 Fort Lincoln Cemetery Brentwood, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735 MD1190 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respirator **Physician** /Medical Obstructive Pulyonary Disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and physician ar s the burial-t Due to (or as a consequence of) Box 68760 Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, reas CHRCER 1 Yes 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 20 No page certificate 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of D. ath 1 Natural 2 Accident 28a. Dat of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending To the Funeral Director: Aft

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date, signed (Month, Dey, Year) 8 CH 30. Name an oddress of person who impleted see of death (Item 23a) (Type, Print) B. Larry Jenkins, md 111 LaGrange Ave. PO Box 2665 LaPlata, MD 20646-1724 32. Registrar's Signature 31. Date filed (Month, Day, Year) JAN 15 State

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Betty May Lomax January 11, 2004 3:30PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7805 Mike Shapiro Drive Clinton Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2X F 74 Yrs Director 075-22-5676 Aug. 23,1929 New York Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits rei', or items 23a or 28a-f show Exemples must be notified at 1 Yes 2 No Maryland Prince George's Clinton Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20735 7805 Mike Shapiro Drive U.S.A. death Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. filed within 72 hours after l □ Yes Z**ON**o If Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0036 Specify: African-1 Yes 2 No Specify by 3 Widowed 4 Divorced ar than "naturel", Year or Dates American
16b. Kind of Business/Industry ted 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Comple nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrator Assistant Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be filt ment of Health and Mental Hitant: If item 27 is marked oth Arthur Leighano Elsie George Tiee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Michael Lomax (Son) 17100 Usher Place Upper Marlboro, Maryland 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 【**XCremation 3 ☐ Removal from State ** 4 ☐ Donation 5 ☐ Other (Specify) Jan. 12, Lee Crematory Clinton, Maryland 2004 Lee Funeral Home, Inc. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 6633 Old Alexandria Ferry Road Clinton, MD 20735 M00542 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician months disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physicien and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical attending ph d for use as th IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregname 1 ☐ Live birth 2 ☐ Fetel death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 DNO 3 Probably 4 ☐Unknown 1 ☐ Yes Completed peeu accide 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performes pade certificate 2 🗌 No 1 Yes 2 1 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 🗀 Inpatient Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 10 1 Yes 2 N 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of ath funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the within 24 hours after deat To the Funerel Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide 1 — strittying "hysiciam. To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7700 Old Branch Avenue #B-102 Clinton, Maryland Sam Tellawi, M.D. 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State JAN 15 Registrar 2004

Medical Examiner 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4c. County of Death 4d. Cou				1 - For State Registrar	State of Marylar		nent of Head cate of De		ental Hygie	4. 4	. 01818
## Facility Name (Fine Instantion of pace area of another) ## Milennium Health and Rehab. Center ## Corr of toestim Of the Section of Section (Procedure) ## Corr of the Section of Section (Procedure) ## Corr of the Section of Section (Procedure) ## Corr of the Section of Section (Procedure) ## Corr of the Section of Section (Procedure) ## Corr of the Section of Section (Procedure) ## Corr of the Section of Section (Procedure) ## Corr of the Section of Section (Procedure) ## Corr of the Section of Section (Procedure) ## Corr of the Section of Section (Procedure) ## Corr of the Section (Procedure) ## Corr					Bloniarz	Lail	SO		Month		10:45 AM
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Sylvester Bloniarz Sylvester Bloniary Sylves		with the Maryler 3s or 28s-f show		Maryland Prince Geo	orge's	Fort Wash	nington f. Zip Code		10g		1 ☐ Yes 2 No
Sylvester Bloniarz Sylvester Bloniary Sylves	36	urs after deat if, or itams 2	þ	1 Never Married 2 Married	Armed Forces? 1 Yes 2X No If Yes, Give		11		ify Yes or No- ican, etc.)	Black, W	hite, etc.
Sylvester Bloniarz Sylvester Bloniary Sylves		filed within 72 hou Hygiene. Ither than "natura int, The Mouleal E	Completed	(Specify only highest grade Elementary/Secondary (0·12) 12th	completed)	(Give kind life. DO N	of work done duri OT use retired) gement	ing most of workin	g	Reta	,
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FFEMALE 23b. West decedent pregnant in the past 12 months? 1 viso 2 No 2 No 3 Probably 4 Propaganatal time of death 5 Other (specify) 23d. Date of delivery Month Day Year 1 Ves 2 No 3 Probably 4 Unknown 24b. Wars and past 25b. Was case referred to medical systems and of the past 1 ves 2 No 3 Probably 4 Unknown 24b. Wars and past 1 ves 2 No 3 Probably 4 Unknown 24b. Wars and past 1 ves 2 No 3 Probably 4 Unknown 24b. Wars and past 1 ves 2 No 3 Probably 4 Unknown 24b. Wars and past 1 ves 2 No 3 Probably 4 Unknown 24b. Wars and past 1 ves 2 No 2	3	/Medical Examiner	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sacus (all y second in the cause in the cause in the cause of the cause or injury that initiated events of the cause of th	Due to (or as a consp	ence of): A	mode of sying,	such as cardiac or	respiratory arrest		Approximate Interval Between
The state of the s	.O. Box	it the death certific by the attending I tached for use as		23b. Wes decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 Fet 4 Pregnant at time of	al death 3 Ecto					
The state of the s		equires tha en signed ould be det	by	Part II. Other significant conditions con	tributing to death but not re	sulting in the underly	ying cause given	in Part I.		. /	
27. Many of Death Natural Signature and title of certifier 28a. Date of Injury 28b. Time of Injury 2		The ate ha		OF Was associated to modified					autopsy performer 1 Yes 2	prior t death	to completion of cause of
27. Many of Death Natural Signature and title of certifier 28a. Date of Injury 28b. Time of Injury 2		sicia s certi		examiner?	ospital:	FR/Outpatient 3	Other			e 6 FlOther (6	nonita)
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and due to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laxmi N. Berwa, M.D., 7700 Old Branch Avenue #C101 Clinton, Maryland 20735	ision of	ding Ph h. After th funeral		27. Man of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes	28 s 2 🗆 No	3d. Describe how	injury occurred	
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Laxmi N. Berwa, M.D., 7700 Old Branch Avenue #C101 Clinton, Maryland 20735	•	To the H within 24 To the F complete	Medi	one)	and manner stated.			umber	29d.	Date signed (Mo	
	-	B3	ate	Laxmi N. Berwa	a, M.D., 7700	Old Branc	h Avenu	e #C101 C	Clinton,	Maryland	d 20735

			For State Registrar	State of Ma	aryland / De <i>C</i>		rtment of H			_	giene Reg. No	6004	01819
			Decedent's Name (First, Middle,	Last)						2. Date of De	ath		3. Time of Death
	Physici		WILLIAM F	ROLAND LA	NCASTER	2	IR			Month 1	Da 5	y Year 2004	7:30 AM
1	/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town, or	Location	of Death			County of Dea	ath
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	Funeral Director		5. Social Security Number 212-48-7502	14/	e (In yrs. last birthda 7 Yrs.		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 6/28/1	th ly, Year) 1946	9. Bi	rthplace (State or Foreign Country) MD
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	eath	eral	11. Marital Status	12. Was Decedent		3. W			igin? (Spe	ecify Yes or No		14. Race - Arr	erican Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It Health and Mental Hygiene. It has 23a or 28a-f show item 27 is marked other than "naturel", or Items 23a or 28a-f show other treumatic event, the Mariest Examiner must be notified at	by Funeral	1 Never Married XXMarrie 3 Widowed 4 Divorced	Armed Forces?	No		/as Decedent of Hi Yes, specify Cuba ☐ Yes ※ No	n, Mexicar Specify:		Rican, etc.)		Black, Wh	_{ite, etc.} White
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an	2 sho and ? Is ma		19a. Informant's Name/Relationshi	o (Type, Print)			Address (Street a						Zip Code)
	and 2 ealth n 27		Kathleen Lar	caster			Herring	1 Rur					21214
5	of He		20a. Method of Disposition 1 ☐ Burial 2 ★Cremation	Removal from State		rem.	atory or other plac		1/7/	04	20c. L	ocation - City o	r Town, State
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Baltimore,	permit. Pages 1 and Department of Heali Importent: If Item 2 any injury or other 2006.		21. Signature of un elervice L	Surfel .		22.	Name and Address 108 Willia	ss of Facili am St	he . Be	Burbag erlin, M	e F	uneral 21811	Home
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Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as I	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		3 □	Ectopic pregnancy				10	23d. Date of de Month	
	deal ne att	sicle	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐Unknown			Other (specify)					Month	Day Year
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2	S .S .E	2	1 XYes 2 □ No	Hospital: 1 Inpatio	ent 2 ER/Outpa	tient		4 🗆 14(me 5 Resi			ecify)
0 =	ng Ph fter th ineral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time y Year) Injur	e of Y	28c. Injun Work			28d. Describe	how inju	ry occurred	
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Division of Vital Records,	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and Zoe. Place of In	ury - At home, farm, c. (Specify)	stre	et, factory, office			28f. Location (: City or To	Street ar wn, State	nd Number or F e)	Rural Route Number,
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•			30. Name and address of person v			pe. F							
7	H. 1		DUROTHY C.	HOLZWORT			203 5	ways	5-	Sunu	Uni	Mn	21863
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				eartment of Health and Mer	ntal Hygier Reg. I	C. L. J. H	01820
	Physici		1. Decedent's Name <i>(First, Middl</i> e, <i>Last)</i> Wanda Faye Lucas		Date of Death Month (anuary	Day Year	3. Time of Death
ı	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	11:20p ^M
			5 Beth Court	Indian Head		Charle	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 M 2 M 45 Yrs. Usual Residence of Decedent	Months Days Hours Min.	Date of Birth Month, Day, Yea pt. 18	9. Birthpi Coun 1958 Vi	elace (State or Foreign htry) rginia
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	ith th or 28	Directo	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Coun	itry?
	eath v	eral	5 Beth Court 11. Marital Status 12. Was Decedent Ever in U.S. 13.	20640	Voc or No.	U.S.A.	ean Indian
36	be filed within 72 hours after death with the Maryland tal Hyglene of other than "natural", or llems 23a or 28a-f show event, the Madical Exactinet must be notified at	by Funeral	1 Never Married 2 Married 1 Yes 2 7 No If Yes, Give 2 3 Widowed 4 Divorced Year of Dates:	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica 1 ☐ Yes ② No Specify:	n, etc.)	Black, White, e	etc.
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Z		일	Ronald B. Latham			Twiford	
Maryland 2	d 2 sh th and 7 is m traum			ing Address (Street and Number or Rural Ro			
<u>ත</u>	as 1 and 2 should of Health and Mer item 27 is marker rother traumalic		20a. Method of Disposition 20b. Place of Dispo	Seth Court, Indian osition (Name of parte place) Date production of the place of t	20c.	Location - City or Tox	wn State
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Baltimore,	permit. Page Department Important: If any injury o		21. Signature of Funeral/Service Licensee M00668	Williams of Eachilly Williams Funeral 4270 Hawthorne Ro	Home,	P.A.	20640
	e.	-	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or head failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ANGER			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
		ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury)				
	cuted nd ransit	Examiner	that initiated events c.				
Ď,	ate be executed hysician and the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):				
98/60	# ≥ e	dlcal	d.				
POX P	leath certifica attending ph I for use as t	n/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	rv
ž Ž	0 0 0	Physician/Med	in the past 12 months? 1 Yes 2 No	□Ectopic pregnancy □ Other (specify)		Month (Day Year
<u>ب</u>	hat the d by t detach		9 ☐ Uniknown Part II. Other significant conditions contributing to death but not resulting in the u	underhing cause gweg in Part I	23a Did tabasas	o use contribute to the	a agues of death?
ďS,	w requires that the been signed by the should be detache	d by	Factor Significant Conditions Contributing to Goden Dut Not resulting in the		1 ☐ Yes	_	
ecord	> 0 70	ompleted			24a. Was an	24b. Were autop	osy findings available
Ľ	9 4 5 1	Com			autopsy performed? 1 ☐ Yes 2 ☐ ♠	death?	npletion of cause of
VItal	ysician: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?	26. Place of Death (Ch			
ō	Phys this ral di	<u>۲</u>	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Manger of Death 28a. Date of Injury 28b. Time of Death		5 → Residence Describe how inj	6 □Other (Specify))
0	nding Phith.	tlon	27. Manner of Death Natural 5 Pending 2 Accident Accident 28a. Date of Injury 28b. Time of In	Work? M 1 ☐ Yes 2 ☐ No	D632130 110W 111	diy occurred	
DIVISION	pital or Atten ours after deat teral Director: filled in by the	ertification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, st building, etc. (Specify)	reet, factory, office 28f. I	ocation (Street a	and Number or Rural	Route Number,
5	urs aft ral Di	O					3
	Ho Ho	edical	29a. Certifier (Check only one) Gertifying Physicien: To the best of my knowledge, deat (2 ☐ Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, and overtigation, in my opinion, death occurred at	fue to the cause(the time, date a	s) and manner as sta nd place, and due to	ited. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, D	lay, Year)
			your My Mall	D78-325		13100	1
1	RIN		30. Name and address of person who completed cause of death (Item 23a) (Type.	Print) Ad	10	646	
İ	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 3 2004 32. Figistrar's Signature	land a		-	
	ricgioti.		Sint - Could Market to De	TO MELI			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** WILLIAM W. LOGAN Q 2004 Janesory /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Meamico KNINSULA REGIONAL MEDICAL SAUIS 64M CONTER 8. Date of Birth (Month, Day, Year) 8-15-1922 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**∑**M 2□F Months Days Hours 81 Yrs. PENNSYLVANIA 180-16-8497 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits worle item 27 is marked other than "netural", or items 23s or 28s-1 show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director DELAWARE SUSSEX LEWES 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19958 US DRIVE 77 PRINCE GEORGE 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 42-45 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 X Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN SEWING MACHINES 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LAURA BLACK WILLIAM W. LOGAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 77 PRINCE GEORGE DR., LEWES, DE. 19958 MARGARET LOGAN/ WIFE 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State MELSON CS CATE (ther place) 1 ☐ Burial 2 XCremation 3 ☐ Removal from State ö Department of important: If eny injury or once. * 4 □ Donation Other (Specify) 1-4-04 FRANKFORD, DELAWARE HENLOPEN CREMATORY 21. Signature of Funera MELSON FUNERAL SERVICES, LTD. LONG NECK ROAD, MILLSBORO, DE. 19966 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final presumed septic Shock+ ollapse **Physician** weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): with ascites, pleural effusions Examiner Mucosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): ending physician a Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? certificate 27**X**(No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Sunpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Yeer) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ddress of person who completed capse of death (Item 23a) (Type, Print) St. Salisbury MD Carroll State Registrar

		•	For State Registrar	State of M	laryland			f Health a of Death	and Me		ene () ()	Ļ	01822	
	Physicia	an	1. Decedent's Name (First, Middle, Last, Josephine		erger	М	iller		2	Date of Death Month Januar	v ^{Da} ¥3. 20	ეშ4	3. Time of Death 6:30A M	
	/Medic Examin		4a. Facility Name (If not institution, give	street and number	-)		4b. City, Tov	m, or Location o			4c. County of	Death		_
	Funeral		Calvert Memor 5. Social Security Number 6. Se		ge (In yrs. las	t birthday)	If Under 1 Y	ear If Under		Date of Birth		Birthpl	ace (State or Foreign	_
	Funeral Director		578-58-0959] м 2[ХूF	93	Yrs.	Months D	ays Hours	Min.	Date of Birth (Month, Day, Sept. 1	9 , 1910 t	7irg	ínia	
	yland now		Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	Town or Loc	cation					10	Od. Inside City Limits	
	e Man Se-fsh diffed	ctor	Maryland Calvert		1	Solom	-			40	g. Citizen of Wh		1 Tyes 2 No	_
	with the	Dire	10e. Street and Number 11450 Ashbury (Circle #2	206		10f. Zip Co 206				.S.A.	it Cour	, ry:	
o O	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dopertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examinar must be indiffed at ance.	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceder Armed Forces 1 Yes 25	it Ever in U.S. 3?]No		Vas Decedent Yes, specify	of Hispanic Orig Cuban, Mexican No Specify:	gin? (Speci i, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Black, Specify:	White, e		
3	hours iturel',	ed by	3 ☑ Widowed 4 □ Divorced 15. Decedent's Edu	Year or Dates ucation	:	16a. Deced	ent's Usual C	ccupation			Sb. Kind of Busin			
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7	filed wi Hygien ther th	e Cor	12 17. Father's Name (First, Middle, Last)	2		Regis	tered		er's Name (First, Middle, M	HEAL1	11 C	are	_
lan.	uld be Aental rked o	To Be	William Granval	e Wil	lberger			J	ennie	Lind S	oupley			_
Mary	nd 2 shoulth and h		19a. Informant's Name/Relationship (7) Linda Salisbur	ype, Print) y (Daught							city or Town, St ia Virg			
nore,	ages 1 au nt of Hea nt: If item / or othe		20a. Method of Disposition 1,		e cem	netery, cren	sition (Name natory or othe	r place) J	anuar	y 16,	Oc. Location - Ci			
заппо	permit. P Departme Important any injury		21. Signature of Funeral Service Licens		Ced	lar Hi	11 Cem . Name and A	etery ddress o Facili	2004 Je		Suitland al Home		-	_
מ	90 E 2		23a. Part i. Enter the disease, or comp	10	1340	Do not ente	633 Ol	d Alexa	ndria	Ferry	Rd Clin	con,	MD 20735 Approximate	
Ģ	Physician	0.3	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a/3 c	line.	col		dying, sauri as	our dide or	- Copilatory arrot			Interval Between Onset and Death	
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9/8	cate be physici the bu	dical	•	d								-		_
O. Box 6	death certifi e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ₹ No 9 ☐ Unknown		2 ☐ Fetal d at time of dea	eath 3□	Ectopic preg Other (spec				23d. Date of Month		ory Day Year	
J .	law requires that the de as been signed by the a 2 should be detached f	Ď	Part II. Other significant conditions of	ontributing to death	but not result	ing in the u	nderlying cau	se given in Part I	l.				ne cause of death? ably 4 □Unknown	
Division of Vital Records,	The ate h page	Completed			-					24a. Was an autopsy perform	ed? de	or to cor ath?	psy findings available mpletion of cause of 22 No	
Vita	icien: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		2/0	2004			(Check only one		(Cassif		METO
on of	Attending Physicien: ir death. ector: After this certific by the funeral director,	tion; To	1	28a. Date of I		R/Outpatien 18b. Time of Injury		Injury at Work?	28		nce 6 Other w injury occurred		7	
Divisi	<u> </u>	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of	Injury - At hom etc. (Specify)	ne, farm, <i>s</i> tr	eet, factory, o	ffice	21	3f. Location (Str. City or Town,		or Rura	d Route Number,	
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical C	29a. Certifier 152 Certifying Ph (Check only 2 Medicel Exen	ysicien: To the be niner: On the basis and manner	s of examination	ledge, deatl on and/or in	h occurred at vestigation, in	the time, date ar my opinion, dea	nd place, ar ath occurre	nd due to the ca d at the time, da	use(s) and mann te and place, an	ner as st d due to	ated. the cause(s)	
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)			30, Name and address of person who	Les A	1D	32a) (Te		77610		~) a vary	//.	200/	_
	133		David J. Tardio	M.D. 11	O Hosp	ital I	Road St	iite 310), Pri	nce Fre	derick,	MD	20678	_
	St Regist	ate trar	31. Date filed (Month, Day, Year) JAN 1 5	2004 32. R	strar's Signatu	Ire A	Sparke).						

	1	For State Registrar	State of	Marylar		artmen rtificat		lealth and M Death	lental Hy	giene Reg. No.	004	01823
Dhombala		1. Decedent's Name (First, Midd	le, Last)	-					2. Date of De	eath Day	Yeer,	3. Time of Death
Physician /Medica	1	EUNICE MAE	MARSHALL						Januar		2004	0959 M
Examine		la. Facility Name (If not institution		/ -	141	4b. City,		Location of Death		•	ounty of Death	
		PN/N3U/A X(9/) 5. Social Security Number	6. Sex 7		last birthday)	If Under		If Under 24 Hrs.	8. Date of Bi		9. Birth	plece (State or Foreign
Funeral Director		214–30–7929	1 □ M 2 🗗 F	,	79 Yrs.	Months	Days	Hours Min.	8. Date of Bi (Month, Da 12/11,	71924	Cou	yland
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arylar show	٦	10a. State 10b. County	′		ty, Town or Lo							1⊠Yes 2 □ No
ath with the Marylan 23s or 28s-f show	Funeral Director	MD Worce 10e, Street and Number	ster	Poce	omoke (10f. Zip	Code			10g. Citize	n of What Cou	intry?
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death	nera	11. Marital Status	12. Was Deced	lent Ever in U	J.S. 13.	Was Dece	dent of H	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No Rican, etc.)	0- 14	Race - Amer Black, White	
after or Ite	F	1 Never Married 2 ☐ Married	rried 1 Tes 2	2 Ø No	Į	1 ☐ Yes	1.0	Specify:	,		nación -	ite
15-0036 72 hours after dee "natural", or flems	od by	3 Widowed 4 Divorce	Year or Dat	les:	16a Dece	dent's Usu	al Occup	ation		16h Kind	of Business/li	
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d with	Completed	Elementary/Secondary (0-12) 12	College (1-	40f 5+)	Home	emake	r			7011	stic	
ind 21215-0036 be filed within 72 hours after death with the Maryland lail Hygiene. d other than "natural", or ttems 23a or 28a-f show event, it a Middical Examinar must be notified at	Be	17. Father's Name (First, Middle						18. Mother's Name	e (First, Middle Aydelo		imame)	
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after des t Health and Mental Hygiene. Item 27 is marked other than "natural", or tlems other traumatic event, the Medical Examination	၉	Raymond Marsh			405 14-17	' Add	(011		-		our State 7	n Cadal
Mar d 2 sh th and 7 is m traum		19a. Informant's Name/Relation		rconal		-		et St., F				
1 and 1 and Healt	1	William Hudson 20a. Method of Disposition	, Esq. (Pe	20b. i	Place of Dispo	osition (Na	ne of		Date		tion - City or T	
mol Pages ent of ht: if i		t⊠ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (tate	cemetery, cre mson C	· .		1/10/	2004	Stock	ton, M	aryland
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or any injury or other fraumatic event, the Medical Exernance.	1	21. Signature of Funeral Pervice		,			177	ss of Facility Elson Fur		ome. F	A.	
Ball permi Depa impo impo any ii		Michael	1) Dec	in	1	03 Li	nden	Ave., Po	comoke	City,	MD 21	
		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that ca it only one cause on ea	used the dea ch line.	th. Do not en	iter the mod	le of dyin	ig, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
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b Sy e	dicai		d	14/	maj	815	_ /	17/5003014	712			
CE Marshall 2/14 I Records, P.O. Box 68 The law requires that the death certifica ate has been signed by the attending phage 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc							23	d. Date of deliv	rery
Shall or P.O. Box that the death cert detached for use	clar	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregna	rth 2 ☐ Fet ant at time of		□Ectopic p □ Other (s		<i>'</i>			Month	Day Year
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Vital Record Sitial Record Sitial Record Sitial The law requir certificate has been serector, page 2 should	Completed								24a. Was	s an opsy ormed2	24b. Were aut prior to o death?	opsy findings available ompletion of cause of
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EVD, on of Vita ding Physician: n. After this cardic	n: To	27. Manner of Death	28a. Date o	f Injury n, Day Year)	28b. Time o		28c. Injur Wor	y at	28d. Describe			,
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Division N or Attending after death. Director: After din by the tune	Certification:	3 Suicide 6 Coule 4 Homicide deter	mined 200. Flace	of Injury - At I	home, farm, s	treet, factor	y, office		28f. Location City or To	(Street and i own, State)	Vumber or Ru	ral Route Number,
DIVI To the Hospital or At within 24 hours after C To the Funeral Direct Completely filled in by	S	29a. Certifier 1 Certify	ing Physicien: To the	best of my kn	nowledge dea	th occurred	at the tu	me date and place	and due to the	a cause(s) ai	nd manner as	stated
To the Hospital within 24 hours a voil the Funeral I completely filled	edical	(Check only 2 Medice one)	Examiner: On the ba	sis of examin er stated.	ation and/or i	nvestigation	n, in my d	pinion, death occur	red at the time	, date and p	lace, and due	to the cause(s)
To the within 2 To the I complet	Me	29b. Signature and title of certif	ler			29	c. Licens	se number		29d. Date	signed (Month	, Day, Year)
		1 12	fe zam	2			D	17/8/		/	17/09	+
6		30. Name and address of perso	n who completed cause	e of death (Ite	em 23a) (Type	e, Print)	,	ie number 17/8/		/		
8 16		31. Date filed (Month, Day, Yea	1 100 E. C	a//o/ istrar's Sign	1/5/.	Sa	list	wry M	2 2/1	804		
Stat Registra		31. Date filed (Month, Day, Yea	8 2004	Strar's Sign	K A	Goed	9	l				

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

	1. 0	Decedent's Nam	ne (First, Midd	le, Last)									2. Date of		0-		3. Time	of Dea
an	J	ohn Tho	mas Ma	nnin	a. Jr.								JANU		Day 18.	2004	1:5	7 P
cal ner		Fecility Name							4b. City,	Town, or	Location	of Death				nty of Death		
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	2	Social Security I 19–86–7	662	6. Sex	M 2□F	7. Age (In	n <i>yrs. la</i> s	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Mgnth) 09/10	Birth Day, Ye	52 52	Cou	plece (Stete intry) yland	or Fo
	-	ual Residence o a. State	10b. Count	у		10	Oc. City,	Town or Lo	ocation							T	10d. Inside (City Li
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Director	104	e. Street and Nu	umber						10f. Zip					10g.	Citizen o	of What Cou	untry?	
	1	08 E. M	lain St	reet					2	21668	3			τ	JSA			
Funeral	11.	. Marital Status		1	2. Was Dec		er in U.S.	. 13.	Was Deced	dent of Hi	ispanic Ori	igin? (Sp	ecify Yes or Rican, etc.)	No-		ace - Amer		
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Be C	17.	. Father's Name		, Last)									e (First, Mid					
To B	J	ohn Tho	mas Ma	nnin	g, Sr.						Doro	othy	Towns	send				
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MARCOT EASTON RYAN MARCOT EASTON RYAN MARCOT E		1 - For State Registrar	State of Maryland /	Certificate of L			. No.	01023
46. Description of Death Atlantic Ceneral Hospital 5. Social Security Function T18-38-3632		MARGOT FAST				Month		3. Time of Death
Source S		4a. Facility Name (If not institution, give	street and number)				•	<u> </u>
The state of the		5. Social Security Number 6. Sex	7. Age (In yrs. last b	Months Days		8. Date of Birth (Month, Day, Y 5 / 22 / 19((ear) 9. Birthpl Coun	lace (State or Foreig try)
Physician (Medical Examiner Medical Examiner M	Dre, Maryland 21215-0036 ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Titiem 27 is marked other than "neturel", or items 23a or 28a-1 show the other traumatic event, the Medical Evant For Foreign and Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD Worces 10e. Street and Number 1 Meadow St. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) William J. Ryan 19a. Informant's Name/Relationship (Tymangot Woods) 20a. Method of Disposition Calculated States (Specify Order) Margot Woods 20a. Method of Disposition Calculated States (Specify Order) William J. Ryan	10c. City, To Be 12. Was Decedent Ever in U.S. Armed Forces? 1	wn or Location rlin 10f. Zip Code 218 13. Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 No If Work done of Iffe. DO NOT use retired Homemaker 25 Clubhous of Disposition (Name of lery, crematory or other place	spanic Origin? (Spen, Mexican, Puerto Specify: ation furing most of works) 18. Mother's Name Mary and Number or Rura e Dr. Oc	ng 16 A Route Number, Cean Pine Date 20	J. Citizen of What Coun USA 14. Race - Americ Black, White, o Specify: Whi Sb. Kind of Business/Inc Own Home Aiden Surname) Franger City or Town, State, Zip S, MD 218 Dic. Location - City or To	NY Od. Inside City Limit Code) NOTE: The second of the
FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 3 Probably 4 Urspective of the cause of death of the cause of death of the cause of death? 1 Yes 2 No 3 Probably 4 Yes 2 No 4 Proprietable for the cause of death of the	Physician /Medical Examiner paul	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Duylo (or as a consequence).	e of): Heart e of):	g, such as cardiac o	or respiratory arres		Approximate Interval Between Onset and Death
24a. Was an autopsy findings are performed? 1 Yes	P.O. Box 6 hat the death certification by the attending letached for use as Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions con	1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)			Month cco use contribute to the	Day Year
25. Was case referred to medical systems of the sys	al Recor					autopsy performe 1 ☐ Yes 2	prior to cor death? No 1 □ Yes	npletion of cause
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and the of certifier (29c. License number) 29c. License number (29d. Date signed (Month, Day, Year))	Division of Vit of or Attending Physicial after death. Director: After this certification: To Be or or or or or or or or or or or or or	examiner?	28a. Date of Injury - At home,	o. Time of Injury Moritan	er: 4 □ Nursing Ho y at k? Yes 2 □ No	me 5 Resident 28d. Describe how 28f. Location (Stre	ce 6 Other (Specif) rinjury occurred net and Number or Rura	
1 (1 Apringe to 400585132 1/10/04	To the Hospite within 24 hours To the Funerel completely filled	29a. Certifier Check only one) 29b. Signature and the of certifier	iner: On the basis of examination and manner stated.	and/or investigation, in my o	pinion, death occurr e number	red at the time, date	e and place, and due to	the cause(s)

-36-3632

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** DONALD LEROY REEDY JANUARY. 2004 2:05AM /Medical 4c. County of Deeth 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Berlin Nursing and Rehabilitation Center Berlin Worcester 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1 XM 2 ☐ F 220-20-4692 76 9/11/1927 MD Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-f ehow the Medical Examiner must be notified at Yes 2 No Selbyville Directo DE Sussex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 19975 USA 30-B Blue Teal RD Swan Keys Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★1 Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. or itame Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 ie marked other than "natural", or iten eny injury or other traumatic event, the Medical Exemplant once. 1 Never Married 2 Married WWII REEDY, DONALD Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 No Specify: White ģ 3€ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) Police Officer Law Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Burke Herman Reedy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2997 Valley View RD Annapolis, MD Shawn Reedy 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1/12/04 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crematory Frankford, DE 22. Name and Address of Facilithe Burbage Funeral Home of Fund al Service Licenses 108 William St. Berlin, MD Zucha 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Vetasta Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Certification: To Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria IF FEMALE: 23c. ff yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown 9 ☐ Unknown signed by Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes ▼☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24a. Was an autopsy performed? 1 Yes 2 3 No after death.

Director: After this certification by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 3□ DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Deat 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 - Homicide within 24 hours a To the Funeral I To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number C es des tel Hoghiva completed cause of death (Item 23a) (Type, Print) C.H. 611 Isla 31. Date filed (Month, Day, Year) 32 Registrar's JAN 13 Registrar

	1. Decedent's Name (First, Midd	State of N 23a&27 PER ME (,				2. Date of De	ath		3. Time of Death
ician dical	Charles Day	vid Reed					January	$y = 13^{3}$, 20ď4°	9:12 A
niner	4a. Facility Name (If not institution		r)		4b. City, Town,	or Location of Dea	th	4c.	County of Death	h
	2001 Kenny Cou				Edgew				Harford	
	5. Social Security Number 219-76-0923 Usual Residence of Decedent	6. Sex 7. A 1 ☐ M 2 ☐ F	Age (In yrs. last 45	Yrs.	If Under T Year Months Days	If Under 24 Hrs Hours Min		1958	9. Birth Co. Ma.	hplace (State or Forei untry) ryLand
	10a. State 10b. County	y	10c. City, To	own or Lo	ocation					10d. Inside City Limit
cto	Maryland Hari	Eord	Ed	lgewo	od					1 ☐ Yes 2 X N
Dire	10e. Street and Number 2001 Kenny Cou	1×+			10f. Zip Code 2104	0		10g. Citiz	zen of What Cor USA	untry?
Funeral Directo	11. Marital Status	12. Was Deceden	nt Ever in U.S.	13.	Was Decedent of	Hispanic Origin? (5	Specify Yes or No	- 1	14. Race - Amer	rican Indian,
þ	3 ☐ Widowed 4 🔀 Divorce	If Yes Give	≱ No		If Yes, specify Cub 1 ☐ Yes 2 No	Specify:	to Rican, etc.)		Black, White Specify:	white
eted	15. Deceder	nt's Education est grade completed)	16	6a. Dece	dent's Usual Occu	pation during most of wo	ndkina	16b. Kir	nd of Business/I	Industry
Completed	Elementary/Secondary (0-12)	College (1-4o		Disa	DO NOT use retire	od)				
Be	17. Father's Name (First, Middle,					18. Mother's Na	me (First, Middle,	Maiden	Sumame)	
ပု	Charlie How					Betty		Honal		
	Betty J. Reed					tand Number or R				ip Code)
	20a. Method of Disposition	,			sition (Name of matory or other pla		Date		cation - City or 1	Town, State
	1 Burial 2 Cremation 4 Donation 5 Other (3 □Removal from Stat Specify)	9			Grdns 1-	-16-04	Aber	deen. N	Maryland
	21. Signature of Funeral Service	Licensee				ess of Facility Houneral Ho			. acciry	Lagrana
	Steply O	Meegls		1	317 Coke:	sbury Roa	ad, Abino	gdon,	MD 210	009
	23a. Part . Enter the disease, o shock, or heart failure. Lis	r complications that cause t only one cause on each	ed the death. D line.	Do not ent	er the mode of dyi	ng, such as cardia	c or respiratory ar	rest,		Approximate Interval Between
ß.	Immediate Cause (Final disease or condition resulting in death)	DIL	ATTEN CADE							
	resulting in deating				PATHY					Onset and Death
		Due to (or a	s a consequence		PATHY					Onset and Death
ner	Sequentially list conditions	b		ce of):	PATHY					Onset and Death
amlner	Sequentially list conditions	b	s a consequences	ce of): ce of):	PATHY					Onset and Death
il Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	s a consequenc	ce of): ce of):	PATHY					Onset and Death
ā	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in information that initiated events resulting in death) Last	b	s a consequences	ce of): ce of):	PATHY					Onset and Death
a	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in information that initiated events resulting in death) Last	b. Due to (or a c. Due to (or a d. 23c. If yes, outcome	s a consequence s a consequence s a consequence	ce of): ce of):				2	3d. Date of delin	
ja	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in information that initiated events resulting in death) Last	b	s a consequences a consequences a consequences	ce of): ce of): ce of):	DEctopic pregnanc	y		2	3d. Date of delin	
E C	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease of Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or a c. Due to (or a d. 23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	is a consequence is a c	ce of): ce of): ce of): ath 3 = 5	Ectopic pregnanc				Month	very Day Year
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			For State Registrar	State of M	arylan		artment of I		ind Menta	al Hygiei Reg.		04	0.028
87			Decedent's Name (First, Middle	, Last)						te of Death			3. Time of Death
B	Physici /Medic		CHARLES	FRANCIS	SI	PALDI	VG			NUARY	-	004	9:40A M
in the	Examir		4a. Fecility Name (If not institution,				4b. City, Town,	or Location of			4c. County of		
				TREET			LA PL	ATA If Under 2	M Hro To B		CHAR		
3.	Funeral Director		5. Social Security Number 218 – 16 – 3355	6. Sex 7. Ag	ge (in yrs. i 80	ast birthday) Yrs.	Months Days			te of Birth onth, Day, Ye J 7	a <i>r)</i> 1924		ece (State or Foreign try) YTAND
07490	put *		Usuel Residence of Decedent 10a. State 10b. County			, Town or Lo	cation						Od. Inside City Limits
	be filed within 72 hours after death with the Maryland tial Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examination resulted at	ţō	MD CHARL	E C		от.АТА	oution						1 Yes 2 No
	or 28s	Director	10e. Street and Number	E-5	ILA I	LAIA	10f. Zip Code			10g.	Citizen of W	hat Coun	try?
	23a 23a ust b	ral	109 HOWARD S	TREET			2064	6			U.S	. A.	
	er dez	Funeral	11. Marital Status	12. Was Decedent Armed Forces	?	S. 13. \	Was Decedent of I f Yes, specify Cub	Hispanic Orig an, Mexican,	in? (Specify Ye Puerto Rican,	etc.)		- America , White, e	
39	il', or	by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1-7 Yes 2 1 If Yes, Give Year or Dates:	W.W.	тт .	Yes 2∏ No	Specify:			Specify:	7 77 7	· corr
5-0036	72 hou		15. Decedent' (Specify only highes.	's Education	w . w .	16a. Deced	tent's Usual Occu	pation	of warking	16b	. Kind of Bus	WH1 siness/Ind	
2	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	kind of work done OO NOT use retire	nd)	or working				
2	filed w Hygier Ather th		17. Father's Name (First, Middle, L	acti		BAR	BER	19 Mothor	da Nama /First		BARBE		T
Maryland	ed fa b	o Be	JAMES CARROL		٦				's Name (First,			"	
37	should be nd Menta marked umatic ev	ဥ	19a. Informant's Name/Relationsh		J	19b. Mailin	g Address (Street		Y M. C			State, Zip	Code)
	0 4 4 4		IRENE SPALDI	NG / WIFE									D 20646
altimore,	m 0		20a. Method of Disposition 1,□Burial 2 □ Cremation	2 Pomoval from State	1 ~	lace of Dispo	sition (Name of natory or other pla	ice)	Date DANUARY	7 20c.	Location - C	City or Tov	vn, State
Ĕ	Pages ment of tant: If it		`4 □Donation 5 □ Other (Sp				HEART C	EM. 1	4. 200		PLA'	TA.	MARYLAND
Bail	permit. Page Department. Important: If any injury o		21. Signature of Funeral Service L	icensee			. Name and Addre	ess of Facility	AREHA	ART-EC	CHOLS	FUN	L.HME.P.
			23a. Part1. Enter the disease, or	complications that cause	M006	Do not ente	11 ST.M	ARY'S	AVE.	LA PI	LATA,		20646 Approximate
ľ	Physician		shock, or heart failure. List of Immediate Cause (Final	only one cause on each l	ine.	1-	5			210.7 21.000			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	aDue to (or as	a donsequ	neulu	<u> </u>	meny			<u></u>		
	Examiner		Sequentially list conditions,	6	Jan	huse	n 1	اسالا	34				
П	pg is	iner	il any leaving to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	iance off.				•			
	be execute sicien and burial-trans	Examine	that initiated events resulting in death) Last	c. Due to (or as	a consequ	ience of):							
8760,	cate be executed physicien and the burial-transii	dical E		d		31,00							
9		ledic		0.									
Rox	death certifi e attending I ad for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			Ectopic pregnanc	v			23d. Date		
	at the dea by the att tached fo	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant a 9☐ Unknown			Other (specify) _	,			Mont	h (Day Year
J.	that the ed by detac	Ph	Part II. Other significant condition	ns contributing to death t	out not mesu	Ilting in the ur	nderlying cause an	ven in Part I.	236	e. Did tobacc	o use contrib	oute to the	cause of death?
Records,	Se Dig	d by	Chrone	V		Luca	Jum			1 ☐ Yes			bly 4 Dunknown
ဂ္ဂ	w require s been si	ojete				0	0 7		248	a. Was an	24b. W	ere autop	sv findings available
T	sician: The law certificate has l irector, page 2 s	Completed							_	autopsy performed? Yes 2	/ de	or to com ath?]Yes 2	sy findings available pletion of cause of
Vital	sician: certifica rector, I	Be C	25. Was case referred to medical examiner?				-	26. Place	of Death (Check		***	2,100	
<u> </u>	Physician: this certific ral director,	မှ	1 ☐ Yes 2 ☑ No	Hospital:		ER/Outpatien	3 DOX		sing Home 5	-			
	ding After fune	Certification;	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investige		iy Year)	28b. Time of Injury	28c. Injud Wood M 1	ryat rk? Yes 2.⊟N		scribe how in	jury occurred	d	
DIVISION	= ° 0 >	ifica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place of In	jury - At ho	me, farm, stre	eet, factory, office	7,00 2,014	28f. Loc	ation (Street	and Number	or Rural	Route Number,
<u> </u>	크림불	Cert	4 Homicide determin	building, et	tc. (Specify,)			City	or Town, Sta	ate)		
	e Hospitel	edical	(Check only 2 Medical E	Physician: To the best xaminer: On the basis of	it examinati	vledge, death ion and/or inv	occurred at the ti-	me, date and opinion, death	place, and due n occurred at the	to the cause e time, date a	(s) and mann	ner as sta	ted. he cause(s)
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier	and manner st	ated.		29c. Licens				Date signed (-	
1	⊢s⊢ŏ		71	nt B	ul.	w	-	0010	209		-10-		
2:	210.	1	0. Name and address of person w				Print)			1			
	710A	IV	HENRY L. BURI				NGE AV	ENUE	LA PLA	TA, M	ARYLA	AND	20646
	Sta	1/2	Date med (month, Day 47 gal)	. בע מוני ני Peyistr	TRUDIC e in	ui O	W						

Registrar

1 -	FOR STATE REGISTRA	V
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		C	ERIIF	ICATE	OF I	DEATH		REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last) Viola Rebecca	Stanley	7					Ja.	ATE OF DEATH DA	10.2	3. TIME OF DEATH 7:53 a.m
	4. SOCIAL SECURITY NUMBER	5. SEX 8	B. AGE (in yrs. las	st birthday)	IF UNDER 1 Y	YEAR .	IF UNDER 24 HRS	7.04	TE OF BIRTH		
	214-30-0401 9e. FACILITY NAME (If not institution, give stree	1 🗆 M 2 🗆 💥	80	YRS.	MONTHS	DAYS	HOURS MIN.	Ju	ne 12,		Virginia
O.B.	503 Beards Hill						LOCATION OF leen	DEATH			NTY OF DEATH [artford
5	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY			100 000							
DIRECTOR	Maryland Hart	ford			r, town on erde		ON				10d. INSIDE CITY LIMITS? 1 Tyes 2 X NO
FUNERAL	10. STREET AND NUMBER 503 Beards Hill	Road			-	101. 2	ZIP CODE 21001				ZEN OF WHAT COUNTRY?
5	11. MARITAL STATUS	2. WAS DECEDENT	EVER IN U.S. AF	MED	13. WA	S DECEN	NDENT OF HISP	ANIC OR	GIN? (Specify Yee	or No—	14. RACE — American Indien.
BY	1 Never Married 2 Merried 3 Wildowed 4 Divorced	FORCES? 1		40	lf y	es, spec	ify Cuben, Mexi ! ☐XNO Spe	ican, Puer	to Ricen, etc.)		14. RACE — American Indien, Black, White, etc. Specify: White
	15. DECEDENT'S EDUCAT	TION	16a. DE	CEDENT'S	USUAL OCC	JPATION			18b. KIND OF BUS	INESS/INC	USTRY
COMPLETED		College (1-4 or 5+)	life	Do NOT us	rork done duri e retired.) :make		of working		Her	Hom	
OME	12 17. FATHER'S NAME (First, Middle, Last)			HOME	marc		18. MOTHER'S I	NAME (Fig	st, Middle, Meiden		
BE C	Arthur R. Posey								ebecca		is
TO B	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS (S	treet and	Number or Rure	al Route N	umber, City or Town	, State, Zip	Code)
F	Anna Mae Godfre	y Daug							·	deen	, Md. 21001
	20a. METHOD OF DISPOSITION 1 17 Burlel 2 Cremetion 3 Remove 4 Donetion 5 Other (Specify)	ni from State	20b. PLACE A	matory or ot			an.13			dorf	Cify or Town, State , Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE	MOO	668	Wi	ME AND	ams F	une	ral Ho	me,	P.A. 20640
	23. PART I. Entar tha diseasea, or cor	un l		_							ian Head, Md.
	SHOCK, OF HEART TAILUTE. LIS	DUE TO (O	on each iine							atory arr	Approximata intarvai Between Onaet and Death
NO O	Sequantially list conditions,	DUE TO (O	R AS A CONSE	DUENCE OF);						Weeks
ICAT	if any, laading to immediata cause. Entar UNDERLYING CAUSE (Disease or injury	DUE TO (O	R AS A CONSEC	MENOS OF							
CERTIFICATION	that initiated avanta resulting in death) LAST	502 10 (0)	H AS A CONSEC	JUENCE OF):						
	PART II. Other aignificant conditions	contributing to de	ath but not r	eauiting i	tha under	rlvina c	ause givan i	n Part i	24e. WAS AN A	UTOPEV	24b, WERE AUTOPSY FINDINGS
MEDICAL	Essentia	Hur	erten	SIDY	1		3		PERFORM	ED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
		, , , , ,							TES 2	NO	OF DEATH?
	DID TOBACCO USE CONTRIB	BUTE TO CAU	SE OF DEA	TH YE	S 🗆 NC		UNCERTA	IN 🗔			
PHYSICIAN:		IOSPITAL:			OTHER:	one)					
<u>×</u>	1 YES 2 NO 1	Inpatient 2 E		□ DOA	4 - Nursing		5 Reeldence	7			
	1 Natural 5 Pending	(Month, Day,		28b. TIME INJU	JRY	WORK	Y AT	28d. D	EŞCRIBE HOW IN	JURY OCC	URED
À	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF II	NJURY — At ho	me, ferm, at				28f. L0	DCATION (Street an	d Number	or Rural Routa Number,
	4 Homicide determined	building, etc	: (Зресну)					Ci	ty or Town, State)		
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA 2 MEDICAL EXAMINER: 0										d, cause(e) and menner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER						9c. LICENSE NU				SIGNED (Month, Day, Year)
8	ManuelMK	/	N				DIST	82	,	Ma	nugry 12.2000
۵ ا	30. NAME AND ADDRESS OF PERSON WHO'S	DMPLETED CAUSE	OF DEATH (ITEM	й 27) (Туре,	Print) 8	La	WS	tre	etin.	. 1	0 5
ŀ	31. DATE FILED (Month, Day, Year) JAN 13 2004	32. RECISTRAR'S	SIGNATURE	-		A	pende	Oin	rlau	10	114 2001
i i	JAN 13 2004	Madia	J K	Dogo	1.3				/		

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. **BALTIMORE, MARYLAND 21215-0020**

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar item #18, 1/16/04, E.T WCHD Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SchuKraft 10:55 AM **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** General Hospital Bell Mayland

| Hunder 1 Year | Hunder 24 Hrs. | 8. Pate of Birth
| Months | Days | Hours | Min. | (Month, Day, Year) Worcester Counte A+lantic 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🙀 F 100 217 46 0164 19,1903 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County th and Mental Hygiene. ?7 is marked other than "natural", or liems 23e or 28e-f shov treumatic event, the Medical Examinat must be multified at 1 Yes 2 No Selbyville Sussex Delaware Directo 10e, Street and Number 10f. Zin Code 10g, Citizen of What Country? U.S.A. 19975 44 Sea Gull Road 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Itimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: White 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) Cheseldine 17. Father's Name (First, Middle, Last) 12 should be fi h and Mental H 7 is marked ot Mary Lucinda Cheseleine Frank Frietsch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 44 Sea Gull Road Selbyville, DE Ada May Shipley 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 1/11/04 Cape Henlopen Crem. Frankford, DE 21. Signature of Funera Arvice Licensee ^{22. Name and Address of Facility} The Burbage Funeral Home 108 William St, Berlin, MD 21811 Julase 23a. Part. Enter the disgase, or complications that each death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myocardial infarction **Physician** /Medical Due to (or as a consequence of): Coronar Examiner atheroscleratic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury resulting in death) Last Due to (or as a consequence of): Box 68760 Completed by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ NO 24a. Was an 1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Hatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide 1 cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Isudine Buygin, no C1-0006795 30. Name and address of person who completed caused death (Item 23a) (Type, Print) Highway Ferrick Island, DE 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

They was

			1 - For State Registrar	State of Maryla	-	artmen rtificat				Reg. No.		0183	Para de la companya d
П	Physici	an	Decedent's Name (First, Middle, Last)	CANDEDC					2. Date of Dea	Day	Year	3. Time of Dea	ın M
8	/Medic		MELVIN ARTHUR 4a. Facility Name (If not institution, give s	SANDERS		4b. City.	Town, or	Location of Deat	Januar	4c. County	of Death	1120	
	Examir	ier	PENINSUUA RESIDI	VM MODILA	CENTE	K		54-1150	UM		1.00	nico	
	Funeral Director		5. Social Security Number 6. Sex 155–32–8583		rs. last birthday 60 Yrs.) If Under Months		If Under 24 Hrs Hours Min.		, Year) 943	9. Birthpl Count West	ace (State or For try) Virgini	reign .a
	and and		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation					10	Od. Inside City Lir	mits
	the Maryl	ector	MD Worcester	Po	comoke	City 10f. Zip	Code			10g. Citizen of V	Vhat Count	1 ☐ Yes 2X] No
	Mith Ba or	ă	2148 Worcester Hwy.	Tot #11			851				ISA	.,,.	
36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Itams 23a or 28a-1 show event, the Medical Examinar must be notified at	by Funeral Director		12. Was Decedent Ever in Armed Forces? 1		Was Deced	dent of H cify Cuba	ispanic Origin? (S in, Mexican, Puer Specify:	specify Yes or No- to Rican, etc.)	14. Rac	e - America k, White, e	etc.	
21215-0036	within 72 hou ene. then "nature he Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	cation	16a. Dece (Give life.	DO NOT us	rk done d	during most of wo	rking	16b. Kind of Bu			
21	filed with Hygiene other the	Co	12		Labor			40 Markada Na	ne (First, Middle,	Well D		ing	
Maryland	should be fill of Mental H markad otl	To Be	17. Father's Name (First, Middle, Last) Guy Arthur Sander							Maiden Sumam McVicker	,		
Mar	2 8 8 2		19a. Informant's Name/Relationship (Type			_			aral Route Numbe				
	es 1 and 2 of Health litem 27 l		David P. Sanders (S		b. Place of Disp cemetery, cre				, Swedes	20c. Location -			
Baltimore ,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		1 ☐ Burial 2 ②*Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	BINOVALIEUM STATE					(2004		•	Maryland	l
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ä	Depa Impo any in		Muchael A	Dean	10	orrowa Orrowa	ıy me ıden	Ave., Po	ocomoke (City, MC	2185	51	
8760,	Property of the price of the pr	Ical Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	addenies ory.	suff on ic	ob	struct	ive lun	g dise	26.30	Interval Between Onset and Death	h
P.O. Box 68	death certific e attending p d for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	□Ectopic pr □ Other (sp				23d. Dat Mos	e of deliver	ry Day Year	
	vires that the signed by the	by	Part II. Other significant conditions con	tributing to death but not thoracoton			4 -	en in Part I.				e cause of death	
Records,	The law requires ate has been sign page 2 should be	Completed	Boleetomy						24a. Was autop perfor	med?	rior to com	osy findings available to a cause 2 No	
ita	ilcian: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?						ath (Check only o				
5	Physician: r this certific ral director,	P	1 ☐ Yes 2 ♠ No H	_	☐ ER/Outpatie			- Indianig i	lome 5 ☐ Resid)	
Division of Vital	Attending Part death. ector: After by the funera	Certification:	27. Manner of Death 1	28a. Date of Injury (Month, Day Year	28b. Time of Injury	M 2	28c. Injury Work	/ at <br Yes 2 □ No	28d. Describe h	ow injury occurr	ed		
DİXİ	ital or Att rs after d ral Direct led in by	Certifi	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, si ecify)	reet, factory	y, office		28f. Location (S City or Ton	itreet and Numbern, State)	er or Rural	Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examination)	sician: To the best of my liner: On the basis of examinant manner stated.	knowledge, dea ination and/or in	th occurred nvestigation	at the tim , in my of	ne, date and place pinion, death occu	e, and due to the durred at the time, of	cause(s) and ma date and place, a	nner as sta and due to	ated. the cause(s)	
	To the h within 24 To the F complete	Σ	29b. Signature and title of certifier	0.0	6 0			number		29d. Date signed			
			110.000000	mehnon	The P.	L	002	2038	1	1-6-	04		
1, 1	1,511	13	30. Name and address of person who co	mpleted cause of death (I	tem 23a) (Type	Print)	1, 01	ord c	100 L	MI	218	201	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Ragistrar's Sig	gnature	C 131	utt	- 0a	lishu	y IV	710	01	
	Regist	rar	EAN A 2 20		11 1	andi.	2						

DHMH 17 Rev 1/2001

Melvin Sanders 155-37-8583

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No AMEND ITEM #8 PER FH G827 1/30/04 Jh 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death _Month **Physician** TANCEANE 0530 Edward Thomas David /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Examiner Boulevard Prince 6-eores 7009 GATENAY District Heights If Under 1 Year | If Under 24 Hrs. Date of Birth 3–22–1948 9. Birthplace (State or Foreign (Month, Day, Yeer) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 11XM 2□ F March 27,1948 Maryland Director 218-54-9425 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show ury or other traumatic event, the Medical Evanimer must be notified at 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Directo District Heights Maryland Prince George's 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 20747 7009 Gateway Blvd. U.S.A. Funerai Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. 1 Yes 2 No
If Yes, Give
Yeer or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Fouipment Operator Dept. of Public Work 11th 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph L. Thomas Lillian B. Tucker 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ling Swee Thomas (Wife) 7009 Gateway Blvd. District Heights, MD20747 13 ^{20c.} Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Jan. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 2004 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery Brentwood, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD M00542 Approximate5 Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Arterios claritic Hypertensive Heart Dis eas /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Physician/Medical Examiner attending physician end I for use as the bunel-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) resulting in deeth) Last been signed by the s should be detached Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed s certificate hes birector, page 2 s 1 Yes 2 710 1 ☐ Yes 2 ☐ No Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death Check only Other: 4 Nursing Home Residence 6 Other (Specify) 12 Yes 2□ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) funeral 28c. Injury et Work? 27. Man Death 28b. Time of 28d. Describe how injury occurred Afteri Natural Injury 5 Pending s efter death. Director: Aft 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) á 4 Homicide ò To the Hospital 24 hours 20a. Cortifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and plane, and due to the cause(s) and manner as stated within 24 hou

To the Funel

completely fi Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registra 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 1 5 2004

32.

Hospital

egistrar's Signature

DHMH 16 Rev 6/95

29d. Date signed (Month, Day, Year)

			1 - For State RegistrarAMEND #8,23a-c	State of Maryl CCHD D	land / Depa 18 14/04 <i>Cel</i>	artment of the strate of the s	Health a	nd Mental Hy	ygiene	14 01033
		100	Decedent's Name (First, Middle, Las.		21,01			2. Date of D	eath	3. Time of Death
	Physic /Medi		LEWIS E.	TWINE				Month	1 7 1	14:34AM
	Exami		4a. Facility Name (If not institution, give	street and number)	- 1	4b. City, Town,	or Location of	Death	4c County of	Death
			University of Man 5. Social Security Number 6. Se	1000	. Ctr.	Balt If Under 1 Year	imre,	MD	Bal	Amore,
4	Funeral Director		224-36-8072 1		yrs. last birthday) Yrs.	Months Days		Min. 8. Date of Bi	ay, Year)	Birthplace (State or Foreign Country)
4		•	Usual Residence of Decedent					712/	11930 NO	orth Carolina
	arylan show	_	10a. State 10b. County	10c	. City, Town or Lo	cation				10d. Inside City Limits
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	with the	F	10e. Street and Number	21		10f. Zip Code			10g. Citizen of Wha	
	leath ns 23	Funeral Director	657 Running Fox I	12. Was Decedent Ever i	in U.S. 13 V	2065		n? (Specify Ves or N	United St	ates American Indian,
9	after or Itan	F	1 Never Married 2 Married	Armed Forces? 1 M Yes 2 □ No If Yes, Give				n? (Specify Yes or No Puerto Rican, etc.)	Black,	White, etc.
03	ours a	1 by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1□Yes 2X No	Specify:		Specify:	white
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23s or 28s-1 show its Medical Evantinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Deced	dent's Usual Occu kind of work done DO NOT use retire	pation during most of	of working	16b. Kind of Busin	ess/Industry
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lan/	ould be Mental l Marked o	To Be	Robert Twine					Twine	,	
Maryland	of 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene. 17 Is marked other than "natural", or Itams 23a or 28a-1 show treumatic event, its Medical Examinal must be notified at	Γ.	19a. Informant's Name/Relationship (T)	vpe, Print)	19b. Mailin	g Address (Street		or Rural Route Numb	er, City or Town, Sta	te, Zip Code)
		1	Shirley Wilson-da				Fox Ro	ad, Lusby,	MD 20657	
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F		 Place of Dispo cemetery, cren 	sition (Name of natory or other pla	ce)	Date	20c. Location - City	or Town, Stete
III III	permit. Page Department of Important: If Iny injury or once.		* 4 ☐ Donation 5 ☐ Other (Specify)	Tr				1-14-2004	Waldorf, i	Maryland
Ba	permit. Departm Importa any inju		21. Signature of Funeral Service Licens	7 1101240	Hu	Name and Addre	wal Ho	me		
8			23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	ications that caused the d	eath. Do not ente	0. Box 1 or the mode of dying	.56, Wa	ldorf, MD ardiac or respiratory a	20604-015	6 Approximate
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16.71 18.77	Examiner		Sequentially list conditions,	MYELOPROL	IFERATI V	E DISORD	ER			day
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Вох	death certiffi e attending p id for use as	Physician/Me	200. Was decedent program	3c. If yes, outcome of pre 1☐Live birth 2☐F		Ectopic pregnancy			23d. Date of	delivery
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Division	or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, stre	et, factory, office		28f. Location (5 City or Tox	Street and Number or vn. State)	Rural Route Number,
	spital ours a naral I		29a. Certifier Certifying Phys	ician: To the best of my k	rougadan daeth					
	To the Hospital or Attentwithin 24 hours after death To the Funaral Director: completely filled in by the	edicai	(Check only 2 Medical Examination)	sician: To the best of my kner: On the basis of exam and manner stated.	ination and/or invi	estigation, in my o	pinion, death o	occurred at the time,	cause(s) and manner date and place, and c	as stated. due to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (Me	onth, Day, Year)
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(2461		30. Name and addless of person who co	mpleted cause of death (I		Print)				
(D	710?		Laschy Sieches A 31. Date filed (Month, Day, Year)	32. Registrar's Sig	1 1 1 1 1	lang land	/ Mend.	CA. BO	extrae,	mp 2/201 "
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State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1:10 AM 10, 2004 January Lorna Thompson /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Charles LaPlata Charles County Nursing and Rehab Ctr. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 💢 F March 2. 1928 England Director 192-24-3773 75 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County Item 27 is marked other than "naturel", or Items 23s or 28e-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Waldorf Charles 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20601 by Funeral 12000 Pierce Road 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11 Marital Status be filed within 72 hours after dal Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify 3 ☐ Widowed 4 🌣 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) furniture sales 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph White Vera Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 end 2 ment of Health a ant: If Item 27 le 12000 Pierce Rd., Waldorf, MD 20601 John Thompson-son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If It eny injury or c 1 ☐ Buriat 2 【Cremation 3 ☐ Removat from State 4 ☐ Donation 5 ☐ Other (Specify) Waldorf, Maryland **Huntt Crematory** 01-12-2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01246 Huntt Funeral Home P.O. Box 156, Waldorf, MD 20604-0156.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final wit **Physician** Laucel disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy 4 Pregnant at time of death Month Year Day 5 Other (specify) signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical examiner? tuneral director, Be 26. Place of Death (Check only one) Hospital: 1 tnpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Vithin 24 hours.

*he Funerel D'

*filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20056949 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) KARAKS #1 BAIQ H.D 20646 HW4 LA PLATA 6620 CRAIN , STK 102 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

				1 - For State Registrar		aryland /		rtment of tificate of			Reg. No.	04	01005
_		Physici		1. Decedent's Nam <i>e (First, Middle, L.</i> Judith	ası) Gale	1	Wadde	:11		2. Date of Dea January		20 ඊ 4°	3. Time of Death 12:55A
		/Medi Examir		4a. Facility Name (If not institution, gi Joseph Ritchie	Hospice			Balt	or Location of Dea		4c. Coun	ity of Death	
		Funeral Director			Sex 7. Age 1 □ M 2 □ F	e (In yrs. last 59	Yrs.	If Under 1 Yea Months Day					lace (State or Foreign htry) t Virginia
		r 28a-f ehow	ctor	10a. State 10b. County Maryland Prince	George's	10c. City, To	own or Loc Llinto		,			1	0d. Inside City Limits 1 ☐ Yes 2 🌠 No
		th with the 23a or 28	ai Dire	10e. Street and Number 3505 Manis Roa	nd			10f. Zip Code	735		10g. Citizen o	What Cour	,
_	5-0036	72 hours after death with the Maryland natural", or Itams 23a or 28a-f ehow dical Examiner must be notified at	To Be Completed by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:			as Decedent of Yes, specify Cu		Specify Yes or No- rto Rican, etc.)	14. Re Bl	ace - Americ ack, White, ify: W	
るが	21215-0	filed within 72 ho Hygiene. Ither than "natur. Ini, I're Medical.	mpieted	15. Decedent's Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5		(Give k life. Di		e during most of wo ed)	1	16b. Kind of		
10	land 2	중 를 중 중	o Be Co	12th 17. Father's Name (First, Middle, Las Hurley	Stoots		Maci	ine Ope	1	ame (First, Middle,			ervice
4	Maryland	and and ie m	-	19a. Informant's Name/Relationship						Bural Route Number			Code)
11 104	altimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or othar tra once.		Fdgar T. Waddell, 20a. Method of Disposition 1 Burial 2XD remation 3 [4 Donation 5 Other (Special Control of the Control o	Removal from State	20b. Place ceme	of Disposi tery, crema	tion (Name of atory or other pl	Jan	-	20c. Location	- City or To	wn, State
_	Balt	permit Depart Import any inj		21. Signature of Funeral Service Lide	~ W∞o≥H;		66		Alexandr		al Home Road C	, Inc	
		Physician /Medical Examiner	8) 1	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused one cause on each lin a. Due to (or as a	the death. Die.	001	the mode of dy	ing, such as cardia	ac or respiratory arr	est, IMG MAL	12.	Approximate Interval Between Onset and Death
	60,	ate be executed thysicien and the burial-transit	If Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a				<i>W</i>				
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dale	.O. Box	death e atter	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 1 = 4 □ Pregnant at 1 = 9 □ Unknown	2 Fetal dea		ctopic pregnand Other (specify)	Э			ate of deliver	ry Day Year
Wa	rds, P	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions	contributing to death bu	it not resulting	j in the und	erlying cause g	ven in Part I.		pacco use con	/	e cause of dea
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1.1	of Vita	Physician: this certificatal director, i	To Be	25. Was case referred to medical examiner? 1 Yes Yes	Hospital: 1 ☐ Inpatier		Dutpatient		her: 4 🗌 Nursing I	ath <i>(Check only on</i> Home 5 ☐ Reside		her (Specifi	pople
3	Division o	Attanding F r death. actor: After i	Certification:	27. Man of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could no	28a. Date of Injun (Month, Day)	Year) 28b.	Time of Injury	28c. Inju Wo M 1	ryat irk?]Yes 2 □No	28d. Describe ho	w injury occur	rred	1
1	Divi	To the Hospital or Attanding Physician: The I within 24 hours after death. To the Funaral Diractor: After this certificate ha completely filled in by the funeral director, page	Certifi	4 Homicide determed	building, etc.	. (Specify)				28f. Location (Sti City or Town	, State)		
		To the Hosp within 24 ho To the Funs completely fi	Medical	one)	nysician: To the best o miner: On the basis of and manner stat	examination a	ge, death o and/or inve	stigation, in my	opinion, death occi	urred at the time, da	ate and place,	and due to	the cause(s)
		To To		29b. Signature and title of certifier	yal M	7		01	30/2	29	9d. Date signe	a (Month, D	ay, Year)
		BIZ		30. Name and address of payson who 31. Date filed (Month, Day, Yer)	completed cause of de	1 1/1/	1001	int)	1 Rd	BIHO	My	2/	2/8
	70	Sta Registr	_	JAW15	2004	r's Signatur	- Ag	MALL!					

			For State Registrar	State	of Marylaı		artment of H tificate of				giene Reg. No.	5004	01836
			1. Decedent's Name (First, Middle,	Last)						2. Date of De Month	ath Day	Year	3. Time of Death
-0.	Physicia /Medic		LOUISE HAZ	EL WAR	RINGT	ON				1	8 ,	2004	6:00 A M
,	Examin		4a. Fecility Name (If not institution,				4b. City, Town, o		of Death		1	County of Death	
			402 South M 5. Social Security Number	Orris St	7. Age (In yrs	last hirthday)	Snow If Under 1 Year		24 Hrs.	8. Date of Bin		Vorceste	lace (State or Foreign
	Funeral Director		217-14-8412	1□ M 2 X F	88	Yrs.	Months Days	Hours	Min.	8. Date of Bin (Month, Da 11/6/1	y, Year) 915	Cour	MD
	D		Usual Residence of Decedent		10.0							1,	Od Inside Obellinha
	arytar show	2	10a. State 10b. County		10c. C	ity, Town or Lo						1	0d. Inside City Limits 11√2 Yes 2 □ No
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	death with the Maryland ms 23a or 28a-f show roust be notified at		402 South Mo	rric St			218	63				USA	,
	ms 2:	Funeral	11. Marital Status		cedent Ever in l	J.S. 13.	Was Decedent of h	Hispanic Ori	gin? (Spe	cify Yes or No		14. Race - Americ Black, White,	
_	s I and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show Item 27 is marked other than "natural", or Items mail be notified at	by Fur	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ ※ ivorced		2 (XNo live		1 Tes, specify Cub 1 ☐ Yes 2 X No		1, PUBICO P	nicari, etc.)		Specify: Wh	
2-003e	72 hou	ted	15. Decedent's (Specify only highest	Education	r)		dent's Usual Occup		t of working)a	16b. Kir	nd of Business/In-	dustry
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and	uld be fi Aental H rked ot tic ever	Be c	William K. Po							Jnknow		oumumo,	
2	2 should be and Mental is marked is umatic ev	၉	19a. Informant's Name/Relationshi			19b. Mailir	ng Address (Street	1				r Town, State, Zip	Code)
Z Z	and 2:		Elaine Masor	1		402	South M	orris	St.	Snow H	Hill,	MD 218	363
ē,	es 1 a of Hea f Item rrothe		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from		Place of Dispo cemetery, crer	sition (Name of natory or other pla	ce)	1/9/0	ate) 4	20c. Lo	cation - City or To	wn, State
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gal	permit. Pages Department of Important: If II any injury or once.		21. Signaturi of Fun Service Li	Jutal		22	Name and Address	ess of Facility Ederal	he B St.	urbage Snow	Fui Hill,	neral Ho MD 21	me 863
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<u>,</u>	execu n and ial-tra	Examin	that initiated events resulting in death) Last	c	o (or as a conse	quence of):							
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7.	law requires that the deas been signed by the 2 should be detached	/Ph	Part II. Other significent condition	s contributing to	death but not re	sulting in the u	nderlying cause gi	ven in Part I		23e. Did t	obacco u	se contribute to the	ne cause of death?
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<u>is</u>	deat deat tor: the	flcat	3 ☐ Suicide 6 ☐ Could no	ot be 28e. Plac	ce of Injury - At	home, farm, str	eet, factory, office		_			d Number or Rura	l Route Number,
2	al or / s after I Dire	Certification;	4 Homicide	buil	ding, etc. (Spec	city)				City or To	wn, State))	
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one) Certifying 2 Medical E	xaminer: On the	ne best of my kr basis of examir inner stated.	nowledge, death nation and/or in	n occurred at the ti vestigation, in my	ime, date an opinion, dea	nd place, a	nd due to the	cause(s) date and	and manner as s place, and due to	ated. the cause(s)
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_	11 0		30. Name and address of person w	no completed ca	use of death (Ite	em 23a) (Type,	Print)		<i>-1</i>	1.	10	Salicbury	wo
<u> </u>	Mid		Charles B. S.1	va, Ir	Pagistraria Sign	134	6 1.00	rician	14 :	suite 11	13	7	21804
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DHMH 17 Rev 1/2001

<i>‰</i>		1 - State Registrar 1. Decedent's Name (First, Middle, L	ast)	laryland	Cer		e of l	Death	2. Date of D			3. Time of Death
Physic		Shirley Wright							Month Januar	Da	y Year 2004	3:07P
/Med Exam		4a. Facility Name (If not institution, g.	ive street and number	7)		4b. City,	Town, or	Location of Deat			c. County of Dea	
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Funera Directo		395-28-1192	Sex 7. A 1 □ M 2XXXF	ge (In yrs. las 7 1		If Under Months	Days	If Under 24 Hrs Hours Min.	B. Date of B. (Month, D. June 1	av Year	932 Wis	rthplace (State or Forei ountry) CONS in
and		Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	Town or Loc	cation						10d. Inside City Limi
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r28a	rec	10e. Street and Number				10f. Zip	Code			10g. C	itizen of What C	ountry?
h with	ai D	17516 Princess A	nne Drive			208	32			USA		
iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event. Its Medical Examination to items to reciting a second or other traumatic event.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	No	lf lf	Vas Dece f Yes, spe l □ Yes	cify Cuba	ispanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or N to Rican, etc.)	0-	14. Race - Am Black, Wh Specify: Wh	ite, etc.
thur sture	ed	15. Decedent's	Education		16a. Deced	lent's Usu	al Occup	ation		16b. I	Kind of Business	
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2 sho and I		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address	(Street a	and Number or R	ural Route Numb	oer, City	or Town, State,	Zip Code)
and ealth		Karen Horneij Br	own/ niece					ive NE,	The state of the s			
of Hoor		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3	☐Removal from State	e cem	ce of Dispos netery, crem	natory`or c	other plac	-,	ulatry		ocation - City of	
ment ment lent: jury		`4 ☐ Donation 5 ☐ Other (Spec	ity)	Bayv	riew C		_		2004			Maryland
permit. Pages 1 and 2 Department of Health a Importent: It item 27 is any injury or other tra once.		21. Signature of Funeral Service Lic	ensee H		Go Go	Name ar	nd Addres Home	s of Facility Cremati	on Serv	ice	P.O. B	ox 784
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Attending Phys r death. ector: After this by the funeral di		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of In (Month, D	jury 28 ay Year)	8b. Time of Injury	M	28c. Injury Work	at	28d. Describe			
tal or Atters at a safter de el Directo ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 280. Place of It	njury - At home etc. <i>(Specify)</i>	e, farm, stre	eet, factory	y, office		28f. Location (City or To	Street a wn, Stat	nd Number or R e)	ural Route Number,
To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex-	Physician: To the bes aminer: On the basis and manners	of examination	edge, death n and/or inv	occurred restigation	at the tim	ie, date and place pinion, death occu	, and due to the irred at the time	cause(s date an	and manner a d place, and du	s stated. e to the cause(s)
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9,7		30. Name and address of person wh	completed cause of	death (Item 2	За) (Туре, і	Print)	7				1 - 1	

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	ryland / I	Departme Certifica			d Mental H	ygiene 2	01.0180	10
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	iysicia Medic		Robert Earl And	erson, Sr					Month	Day 23, 7	Yeer 11 20 A	₩.
The second second	kamin		4a. Facility Name (If not institution, give	street and number)		4b. City	, Town, or	Location of D		4c. County		
			Union Memorial Hos	spital		E	altin	more		N/A		
Fur	neral		5. Social Security Number 6. Sec	144 OCT C	(In yrs. last bii	rthday) If Unde	r 1 Year	If Under 24			Birthplece (State or For Country)	reign
Dire	ector			M 2□F	57	Yrs.				7, 1946	West Virgini	ia-
and *		ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or Location					10d. Inside City Lin	
Aaryl f eho	a be	ō	Maryland N/A		_	timore					1 Tyes 2	
the h	illia	ect	10e. Street and Number		Dail		p Code			10g. Citizen of W		
with	116	ā	1337 W. 42nd Stre	act		101. 21		1211			,	
Jeath Tre 23	THE STREET	Funeral Director		12. Was Decedent E	ver in U.S.	13. Was Dece			? (Specify Yes or N	US 14. Race	A American Indian,	
the second	ALTER A		1 Never Married 2 Married	Armed Forces? 1	0				? (Specify Yes or Nuerto Rican, etc.)	Blac	k, White, etc.	
5-0036 72 hours after death with the Maryland netural; or Iteme 23a or 28a-f ehow	Exe	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	Viet Na	am 1 Yes	2 No	Specify:		Specify	White	
21215-0036 ad within 72 hours aft giene. er than "natural", or	lica lica	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a.	Decedent's Usi (Give kind of w			working	16b. Kind of Bu		
14 in in in in	W	du	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO NOT	ise retired,)	g			
Fed y Sie tra	it.		9			laintena	nce F			Deutsch	e Bank-	
Dan fi	9.0	Be	17. Father's Name (First, Middle, Last)				ĺ	18. Mothers	Name (First, Middl	e, Maiden Sumami	9)	
Dould Me	natic	၉	Donald Anderson 19a. Informant's Name/Relationship (Ty	en a Christi	405	. M. 10 M. A. A	- /0	V	irginia_	Herndon		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-1 show	traur	П	Margaret Anderson						r Rural Route Num			
Heall	the c	ŀ	20a. Method of Disposition	M T T		f Disposition (Na ry, crematory or	4∠∏ Q me of	stree	t Baltin	nore, Mar	vland 21211 City or Town, Stete	
Baltimore, bermit. Pages 1 ar Department of Hear mportant: If item	101		1X☐ Burial 2 ☐ Cremation 3 ☐ R	lemoval from State							•	
Hir. Partme	injur.		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Fureral Service License	00 0	laikw	rood Ceme			28/2004	Parkvill	e, Maryland	
Be Fee	any i		* Amara /	2 (No.	11)	Burge	e-Hen	ss-Sei	tz Funera	1 Home.	Inc. 21211	
		+	23a. Part1. Enter the disease, or compli-	ications that caused	the death. Do	3631	alls	Road,	Baltimor	e, Maryl	and Approximate	_
Land.			shock, or heart failure. List only or immediate Cause (Final	TO CAUSE OIL BACK! IIII	e.		, ,	,	,		Interval Between Onset and Death	
Physic /Med		-	disease or condition resulting in death)	Kenal	consequence	uu one					Tuay	5
Exam	iner			Aculter	Z. C.	in ator	D	iction	> Syn	diane	3 day	
		Je.	Social field in the state of th	Due to (or as a	consequence		7	13 1 00 2.	0-111	C)CC/0/2C	5	
cuted	ransii	Examiner	that initiated events	.								
e exe	rial-t	Ä.	resulting in death) Last	Due to (or as a	consequence	of):						
I Records, P.O. Box 68769, The law requires that the death certificate be executed to has been signed by the attending physician and	the burial-transit	ca		ı								
K 61 ertific ing p	be detached for use as t	Physician/Med	IF FEMALE:							100		
Box sath cert attending	or us	au/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth	Fetal death					23d. Date Mon	of delivery th Day Year	
P.O.	peq	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	ime of death	5 Other (s	oecify)				or Day Tour	
that the bed by	detac		Part II. Other significant conditions con	tributing to death bu	t not resulting in	the underlying	cause dive	n in Part I	23a. Did	tobacco use contri	bute to the cause of death?	,
Records, The law requires t te has been signe	ed b	0	Febrile Neu	tuoren	ia	,					3 ☐ Probably 4 ∭Unkno	
V requ	should	Completed	Small Coll CARC	inona	with	METS	مد	Time.	-		• • • • • • • • • • • • • • • • • • • •	
Re he lay he lay	99 2	E				- 11	10	11451	— 24a. Was — auto perf	psy pr	fere autopsy findings availa for to completion of cause of eath?	
Vital Fidelandician: The certificate	or, pa		And Bene 25. Was case referred to medical	with Ti	lecent	CHEM	stran	apy			Yes 2 No	
Vision of Vital Attending Physician: r death.	lirect	10 18	examiner?	lospital:	2 DEBIO	tpatient 3 D	Othe:		Death Check on			-
Of Phys	eral o		27. Manner of Death	28a. Date of Injury	28b. T		28c. Injury Work	at Nursin	g Home 5 ☐ Res	how injury occurre		
	un e		1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) in	njury M		? ′es 2 ☐ No				
Division of Vital for Attending Physician: after death. Director: After this certifica	by th	20	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ry - At home, fa	rm, street, factor	y, office				r or Rural Route Number,	
S afte	u pe	Certification;	4 Homode	building, etc.	(Specify)				City or To	wn, State)		
Division (To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After	cumpletely filled in by the funeral director, page	edical	29a. Certifying Phys (Check only one) Certifying Phys Certifying Phys	her: On the basis of i	examination and	, death occurred d/or investigation	at the time	e, date and pl inion, death o	ace, and due to the ccurred at the time,	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)	
o the	empli		29b. Signature and title of certifier	and manner stat	5 .	29	c. License	number		29d. Date signed	(Month, Day, Year)	
F3F	0		1 7.	000	. ur		100	- (all	C NIX	10-110		
21		4	30. Name and address of person who co	mpleted cause of de			1041	1045	5 N/3/14	- OMNO 19C	7 23, 2004	
51			2.4 2	ressit P	a(ii (itelii 25a) (Alh		14 2	1218		
	Stat	е	31. Date filed (Month, Day, Year)	32. Registra		-	1			************		
Re	gistra	r	IAN 2 7 2004	General	19	Ann V						

		-	For State of Maryli		epartment of Health : Certificate of Death	•	giene	01839
3.			. Decedent's Name (First, Middle, Last)			2. Date of De		3. Time of Death
ائي. سمه	Physicia		Horace Franklin Ab	ee		January	Day Year 7 22. 2004	11:50 P ^M
	/Medic Examin		la. Facility Name (If not institution, give street and number)		4b. City, Town, or Location		4c. County of Dea	
	Examin	eı	7 Dovetail Lane		Essex		Baltimor	2
-	Funeral			yrs. last birtho	(ay) If Under 1 Year If Under	r 24 Hrs. 8. Date of Birt	h 9 Bir	thplace (State or Foreign
	Director		237-24-9991 N□M 2□F 80	Yr	Months Days Hours	Min. (Month, Da Oct. 25	, 1923 Nor	th Carolina
Č.		ŀ	Jsual Residence of Decedent					
	yland		10a. State 10b. County 10c.	. City, Town o	or Location			10d. Inside City Limits
	Mar a-f s	بۆ	Maryland Baltimore	E	ssex			1 ☐ Yes 2 X No
	r 28	ire	De. Street and Number		10f. Zip Code		10g. Citizen of What Co	ountry?
	h wit		7 Dovetail Lane		21221		U.S.A.	
	death with the Maryland oma 23a or 28a-f show or rest be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever i Armed Forces?	in U.S.	 Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica 	rigin? (Specify Yes or No	- 14. Race - Ame Black, Whi	
0	after or ite	교	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No 1 If Yes, Give	943-	1 ☐ Yes 2 X No Specify		Specify:	
0000	72 hours atter natural', or ite	1 by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1	945			Ороспу.	White
ה ה	72 h	etec	 Decedent's Education (Specify only highest grade completed) 	(0	ecedent's Usual Occupation Give kind of work done during mo	est of working	16b. Kind of Business	/industry
7	within ene. then	gu	Elementary/Secondary (0-12) College (1-4or 5+)		ife. DO NOT use retired)		Steel Pla	n+
V	filed w Hygier ather th	Completed	8		Brick Mason	ner's Name (First, Middle,		IIIL
yland	tal H d oth	Be	17. Father's Name (First, Middle, Last)			25 - 1111 (
<u>X</u>	2 should be and Menta is marked surmatic ev	2	Esley Abee			nnie Mae Sho		= 0
Mar	2 sh and is m		19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Street and Numb			Zip Code)
≤ (1)	s 1 and 2 should be filed within 72 hours atter death with the Marylan Health and Mental Hygiene. It Health and Mental Hygiene. It have 12 is marked other than "natural", or itema 23a or 28a-1 show item 27 is marked other than "natural", or itema 23a or 28a-1 show other traumatic event, the Madical Examiner round by notified at	-	June Abee (Wife)		ovetail Lane Es	Date Date	20c. Location - City or	Town State
TOL	pes 1 If ita or ot		1 Burial 2 Micremation 3 Linemoval from State	cemetery,	disposition (Name of crematory or other place)	Jan. 24,		
	men tant: jury			Bayview	Crematory Inc	2004	Baltimore,	. Maryland
Dalt	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other once.		21. Signature of Edneral Service Lipensee	Le	22. Name and Address of Facil Bruzdzinski Fur 1407 Old Easter	neral Home F	A Geey Mary	land 21221
45			23a. Part1. Enter the disease, or complications that caused the cauced the shock, or heart failure. List only one cause on each line.	death. Do no	t enter the mode of dying, such as	s cardiac or respiratory a	rrest,	Approximate Interval Between
	Dhysisian		Immediate Cause (Final	h 0	to 71	a sufficul	OG CAA	Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as a con	sequence of	Vorg I	301///01	1100	o years.
	Examiner		Chan	nic	Obstructi	ille Pielm	and Dx	6 Years
Q.	()	-e	Sequentially list conditions, if any, leading to immediate Due to (or as a con	nsequence of	1	0 . / 0. [
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.					
o Î	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial transit		resulting in death) Last Due to (or as a con	nsequence of);			
28/60	icate be physici s the bu	edicai	d					
_	ng ph	Ved	IF FEMALE:					
X Q R	eath certiff attending I I for use as	an/I	23b. Was decedent pregnant 23c. If yes, outcome of pro		3 □Ectopic pregnancy		23d. Date of de Month	livery Day Year
	a dea	Physician/M	in the past 12 months? 1 Yes 2 No	of death	5 Other (specify)		None	Day 100.
j	at the de I by the a stached	hy	9 Unknown					- the course of death?
ر ک	res that igned b	þ	Part II. Other significant conditions contributing to death but not	1 1			obacco use contribute t	
ב	w require been si should b	ted	Tille Fibile	14/10	η		Yes 2 □ No 3 □P	robably 4 Unknown
ecords,	as be	pje	ffy perfensi	02		24a. Was	osv prior to	utopsy findings available completion of cause of
Ť	hysician: The law his certificate has b I director, page 2 s	Completed				perfo	rmed? death? 2⊠No 1⊟Ye	s 2 No
Ita	ian: ortifica	Be (25. Was case referred to medical examiner?		26. Plac	ce of Death (Check only		
_	nysic dire	10		2 ☐ ER/Outp		Nursing Home 5 🕍 Resi	dence 6 Other (Spe	ecify)
0	ding Ph h. After thi funeral		27. Manner of Death 1 X Natural 5 ☐ Pending (Month, Day Yea	28b. Tir ar) Inj	me of 28c. Injury at Work?	28d. Describe	how injury occurred	
0	death. ctor: A y the fu	atic	2 Accident investigation		M 1 Yes 2			
Division of Vital R	or Att ter d irect	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (Sp.		n, street, factory, office	28f. Location (City or To	Street and Number or R wn, State)	lural Route Number,
	oital o urs at arat D	Ce	M	lease de des	4			=
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	edical	29a. Certifier (Check only one) 1X Certifying Physician: To the best of my and manner stated.	mination and	or investigation, in my opinion, de	eath occurred at the time,	date and place, and du	e to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier	2 2	29c. License number		29d. Date signed (Mon	1
)			1 Han	D,0	135	593	1123	12804
	17		30. Name and address of person who completed cause of death	(Item 23a) (T		ve Bat	Smark 1	10000
	2		31. Date filed (Month, Day, Year) 32. Registrar's S	1/2 Signature	4 Mace A	ve, val	1,010	11 2 12 2
	Sta Regist		31. Date filed (Month, Day, Year) JAN 2 7 2004 32. Registrar's S		Ann. W			

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Marylan	id / Department Certificate		lental Hygien	2004	01810
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last, Henry Will 4a. Facility Name (If not institution, give	Iliam Bo		Own, or Location of Death	JAN. 2	c. County of Deat	h
3	Funeral Director		Usuel Residence of Decedent	M 2□F (last birthday) If Under 1 Months Months	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Yea 10 - 5 - 4	9. Birtl	1000
ם ב	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Heatith and Mental Hygiene. Tordant: If tien 27 is marked other than "natural" or items 23a or 28a-f show injury or other treumatic event, the Modic. Examiner must be rucilised at injury or other treumatic.	To Be Completed by Funeral Director	10a. State 10b. County MD HARFO 10e. Street and Number 10e. Street and Number 10e. Street and Number 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade (Spe	12. Was Decedent Ever in U Amped Forces? 12. Yes 2 No 17'es, Give Year or Dates: Jucation (e completed) College (1-4or 5+)	S. 13. Was Decede If Yes, specification of the State of S	Occupation done during most of work retired)	ecify Yes or No-Rican, etc.) 16b. 18 Sidente 6 (First, Middle, Maide	avis.	nican Indian, a, etc. hite. Industry Credit I'm Service
baltimore, mar	permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is m any injury or other treum 20028.		20a. Method of Disposition 1 Burial 2 Cremation 3 F Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	Bohrye-Wife. Removal from State M+. Removal from State	Place of Disposition (Name semetary, crematory or other and Canal 22. Name and FVANS	er place) Hery 1-22 Address & Facility NE	Date 20c. PORT DE LAPEL-BELL	21015 Location - City or	Town, State MD. HILL, MD 21050
Von, S	ate be executed // Medical Insurant Italians Ita	licai Examiner	23a. Part1. Enter the disease or comp shock, or heart failure. Ust only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Disease or Injury that initiated events resulting in death) Last	a. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of):		or respiratory arrest,		Approximate Interval Between Onset and Death
ň	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of d 9 □ Unknown	ol death 3 Ectopic pres			23d. Date of deli Month	very Day Year
coras, r	v requires that the been signed by th should be detache	ompleted by Pl	Part II. Other significant conditions co	ntributing to death but not res	ulting in the underlying cau	use given in Part I.		2□No 3□Pro	the cause of death? bbably 4 □Unknown topsy findings available
от Упан ме	Physicien: The lar this certificate has ral director, page 2	To Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 反 No 27. Manner of Death		ER/Outpatient 3 DOA	Other: 4 Nursing Ho	autopsy performed? 1 Yes 2 N	prior to death? 1 Yes	2 No
DIVISION	deal deal ctor: y the	Certification;	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At h building, etc. (Specif	Injury M ome, farm, street, factory,	Work? 1 ☐ Yes 2 ☐ No	28f. Location (Street a City or Town, Sta	and Number or Ru	ral Route Number,
	To the Hospital or A within 24 hours after To the Funerel Dire completely filled in b.	Medical (29a. Certifier (Check only one) 29b. Signature and title of certifier	rsician: To the best of my knotiner: On the basis of examina and manner stated.	owledge, death occurred at ation and/or investigation, is 29c. pn 23a) (Type, Print) N - Characters	the time, date and place, n my opinion, death occur License number	and due to the cause(red at the time, date and 29d. D	s) and manner as nd place, and due ate signed (Mont!	stated. to the cause(s) o, Day, Year)
	go'\	ate	30. Name and address of person who could be a second of the second of th	ompleted cause of death (Iter	m 23a) (Type, Print) O) N-Cha	ules St.	Balto. m.	1 2120	4
	Regist		JAN 2 7 2004	1000 100	Aprile!				

			•	State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 8 1 For State Registrar Certificate of Death Reg. No.
		Physici /Medic		1. Decedent's Name (First, Middle, Last) NISON TUCNER Ballard, Jr. 2. Date of Death Month Day Year January 21, 2004 8:50 AM
		Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4d. County of Death 4d. County of Death 4d. County of Death 4d. County of Death 4d. County of Death 4d. County of Death 4d. County of Death
		Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year II Under 24 Hrs. Min. Days Hours Min. Day, Year) Country) 2 19 - 28 - 3136 Min. Days Hours Min. Days Hours Min. Day, Year) Country) 3. Date of Birth (Month, Day, Year) Country) 3. Baltendary Processing Country) 4. Age (In yrs. last birthday) If Under 1 Year II Under 24 Hrs. Min. Days Hours M
		the Maryland 28a-f show	٥٠	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 22 No
₩ t	4	with the Ma 3e or 28a-f 1 be notifie	Funeral Director	10e. Street and Number 10f. Zip Code 10f. Zip Code 10g. Citizen of What Country? 2/152 (1 5 A.
0.	9	within 72 hours after death with the Maryland ene. Han "natural", or itema 23e or 28e-f show ha Medical Examiner must be notified at		11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 Never Married 2 Married 2 No IYes, Give 1 1 Yes 2 No IYes Specify: 1 Yes 2 No Specify: Speci
8:5	215-0036	"natural", edical Eva	leted by	3 Widowed 4 Divorced Year or Dates: WW 72 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
W	S :	filed within Hygiene. other than	e Completed	Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
į		2 should be filed and Mental Hygia is marked other aumetic event, III	To Be	Wilson Turner Ballard, Sr. Susan Catherine Reaney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
07	_	s 1 and 2 should be filed with I Health and Mental Hygiene. tiem 27 is marked other than other traumetic event, the Mental Hygiene.		Mr. Benjamin W. Ballard (SO1) 9401 Lyons Mill Rd. Owings Mills, MD, 21117 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State
211	<u>-</u>	nit. Page: artment o ortant: If injury or injury or		1 Burial 2 Cremation 3 Removal from State Evans Funeral Chapel Beldin Jan, 22, Forest Hill, Maryland 21. Signature of Funeral Service Licensee
	Ba	permit. Departi Import sny inj		23a. Petri. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25. Name and Address of Failure 4. The name and Address of Failure 4. The name and Address of Failure 4. The name and Address of Failure 4. The name and Address of Failure 5. Name and Address of Failure 6. The name and Address of Failure 7. The name and
	P	Physician /Medical		shock, or heart failure. List onty one cause on each line. Interval Between Onset and Death disease or condition resulting in death) Due-to (or as a consequence of):
١	E	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or s a consequence of): Leasure Volume Vol
0	ó	ate be executed hysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): Due to (or as a consequence of):
	68760	ate hys	Medical	IF FEMALE:
ARI	O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 9 Unknown
17-	rds, P	w requires that been signed b should be deta	ed by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available
BAI	l Records,	The law requisate has been page 2 should	Completed by	24a. Was an autopsy findings available prior to completion of cause of death? 1 \[\subseteq 8 \] 1 \[\s
	of Vital	ysician: is certific director,	To Be (25. Was case referred to medical examiner? 1
SOL	Division	ding After funer	Certification:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Sec. Injury at Work? 4 Natural 5 Pending (Month, Day Year) 3 Suicide 6 Could not be 28a. Date of Injury 4 North Pending 1 Pending (Street and Alumbrase Sun Sun
711	5	i te		4 Homicide determined building, etc. (Specify) 256. Face of injury - At norme, farm, street, factory, onice building, etc. (Specify) City or Town, State)
3	-	the Hos nin 24 h the Fur npletely	Medical	29a. Certifier (Check only one) 29b. Signature 1 Tile of priffer (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)
	,	T with		Manyaro D 22627 1/21/04
		17		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS SANZARO - BROADMEAD - 13801 YORK RD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature
		Sta Registi		JAN 2 7 2004 As A A COME

BONTHRON, RUTH 1.25-04 1:50 AM Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

			pe or Print in				-		egible.	
	1	For State Registrar	State of Maryla		epartment d C <i>ertificate</i>			iene	2004	01840
Physician /Medical		1. Decedent's Name (First, Middle, Last)	+1.	F	3 ONTH	HRON	2. Date of Deat Month ANUARY	Day 25	200-	3. Time of Death
Examiner Funeral Director	4	La. Facility Name (If not institution, give structure) GILCHRIST 5. Social Security Number 6. Sex	eet and number) ENTER 7. Age (In yr	00	iday) If Under 1	wn, or Location of Dea VSO N Year If Under 24 Hrs lays Hours Min	8. Date of Birth	B	9. Birtho	NORE Nace (State or Foreign try) RVI AND
D		10e. Street and Number 6835 CAMPFI	ORE 10c. 0 ELD ROAD, Was Decedent Ever in Armed Forces?	BAL Apr 5	13. Was Deceden		1 Specify Yes or No-	(n of What Cour	ean Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at ones. To Re Commissed by Funeral Director	to possible of	1 Never Married 2 Married 3 New Midowed 4 Divorced 15. Decedent's Educa (Specify only highest grade of the company (0-12) 17. Father's Name (First, Middle, Last)	1 Tes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 €	No Specify: Occupation done during most of wo		16b. Kind	of Business/In	HITE
and 2 should be file as the and Mental H m 27 is marked out in traumatic even To Re	3	17. Father's Name (First, Middle, Last) RICHARD F 19a. Informant's Name/Relationship (Type LYNN CASE BERE	R. HEA DAUGHTE		Mailing Address (S	18. Mother's Na A Citreet and Number or R	RGARET	E	E. J.	ONES COOO) E ARIZOU
permit. Pages 1 a Department of He- Important: If Item any injury or othe once.		20a. Method of Disposition 1 Surial 2 Cremation 3 Reg. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligensee	noval from State	cemetery MOST	8800 H	METRY JA Address of Facility E ARFORD R	N30.2001 VANS FU B. PARK	BAI NERA VILLE		own, State
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications, or hear failure. List only ode Immediate Cause. Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Exter Underlying.	Due to (or as a cons	han equence o	ui C	ar did in	=,	ny		Inflerval Between Onset and Death
execute in and ial-trans		cause. Enter Underlying Cause Circles or injury that initiated events resulting in death) Last c.	Due to (or as a cons		():					
requires that the death certificate be signed by the attending physicial hould be detached for use as the buryed hy physicial and Madical) Sicial C	23b. Was decedent pregnant in the past 12 months? 1 Yes	c. If yes, outcome of prec 1 ☐ Live birth 2 ☐ Fo 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death	3 □Ectopic preg 5 □ Other (speci			230	f. Date of delive Month	ory Day Year
w requires that been signed should be de		Part II. Other significant conditions conti	ibuting to death but not r	resulting in	the underlying caus	se given in Part I.	1 □ Y€	s 2 1	¶o 3∏Prob	ne cause of death?
The la ate has page 2		25. Was case referred to medical				Of Place of De	24a. Was a autops perform 1 Yes 2	ned? No	24b. Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of
Phys this al di	2	avaminar?	spital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Out		Other	Home 5 Reside	ence 6°5	Öther (Specif	Hopize
ital or Attending Purs after death. ral Director: After to lied in by the funera		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Albuilding, etc. (Spe	ecify)			28f. Location (St City or Town	i, State)		
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	INCOLOR IN	29a. Certifier (Check only one) 1 Certifying Physic (Check only one) 2 Medical Examine 29b. Signature and title of certifier	cian: To the best of my ker: On the basis of examinand manner stated.	knowledge, ination and	or investigation, in	my opinion, death occ	urred at the time, d	ate and pl	ace, and due to	o the cause(s) Day, Year)
10		30. Name and address of person who com	pleted cause of death (ey;	Type, Print) N-CR	reles St.	Balts	JAN	1 21	25,200x
State Registra		31. Date filed (Month, Day, Year) JAN 2 7 2004	32. Registrar's Sig	gnature	Calle					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 10:209M Florence Bain /Medical 4e. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Franklin Square Rosedale
If Under 1 Year | If Under 24 Hrs. Center Hmore Hospital 8. Date of Birth (Month, Day, Year) Aug. 25, 1932 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 □ M 2 1 F Days Hours Maryland 219-28-4479 Yrs. Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits worle item 27 is marked other than "natural", or itame 23a or 28a-f eho other traumatic event, the Mactical Examinar must be notified at 1 Yes 2 No Director Md. Baltimore Dundalk 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3511 Loganview Drive 21222 USA Funerai death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2X No Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Meat Wrapper 10th Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or othar traumatic event Joseph Weber Marv Brannock 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3511 Loganview Drive Baltimore, Md 21222 Karl Bain (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 1/27/04 Baltimore, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility aczorowski Funeral Home, PA 1201 Dundalk Ave Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical Examiner ney monig Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sicien and burial-transit Se 0515 death certificate by execu Due to (or as a consequence of): Physician/Medical rrhosis lbe. phys as IF FEMALE use a 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 Live birth 2 Fetal death for in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a I ☐ Yes 2 ☑ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛱 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Benal has autopsy pertormed? page certificate 1 ☐ Yes 2 🗷 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending After Injury 1/XNatural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 (X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 (in Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I 29b. Signatury and title 29c. License number 29d. Date signed (Month, Day, Year) address of person who cause of death (Item 23a) (Type enneth Guare. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 7 2004 Registrar

21215-0036

Itimore,

P.O. I

Division of Vital Records,

			For Sta	te of Maryland / De	epartment of He	alth and Mental Hy	_	01811
			1 - Stete Registrer	C	Pertificate of De	eath	Reg. No.	\$7 1 Q 5. 5°
	Dharaisi	·	1. Decedent's Name (First, Middle, Last)			2. Date of De	aath Day Year	3. Time of Death
	Physici /Medio		Ruth Inez Berends			Janua	22 200	H 11:10 PM
	Examin		4a. Facility Name (If not institution, give street a	and number)	4b. City, Town, or Lo		4c. County of Dea	
			Franklin Souare Hos	pital Center	Rosed	ale	Baltim	nne
-	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birtho	(ay) If Under 1 Year	f Under 24 Hrs. 8 Date of Bir	th O Die	thplace (State or Foreign
	Director		411-48-3997 1 ¹ M ²	火 F 71 Yrs	Months Days	Hours Min. (Month, Da	25,1932 Te	ountry) NNESSEE
			Usual Residence of Decedent					
	ylan bow		10a. State 10b. County	10c. City, Town o	r Location			10d. Inside City Limits
	Mar Mar	Ş	Maryland Baltimore		Baltimore	2		1 □ Yes 2 XNo
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Co	ountry?
	be filed within 72 hours after death with the Maryland Hygiene. do chher than "neturel", or items 23a or 28a-f show event, the Madical Examination use to addition at		4107 Slater Avenue			21236	U.S.A.	
	ms 2	Funeral	11. Marital Status 12. Wa	s Decedent Ever in U.S.	13. Was Decedent of Hisp	anic Origin? (Specify Yes or No Mexican, Puerto Rican, etc.))- 14. Race - Ame	
0	riter .	Ē	1 ☐ Never Married 2 ☐ Married 1 ☐	Yes 2 🕅 No			Black, Whit	
000	within 72 hours after ene. than "neturel", or Ite	Þ	3 X Widowed 4 □ Divorced Ye	es, Give ar or Dates:	1 ☐ Yes 2 🛣 No	Specify:	Specify:	White
Ž	2 ho	ted	15. Decedent's Education	16a. De	ecedent's Usual Occupation	on	16b. Kind of Business	/Industry
<u></u>		음	(Specify only highest grade comp Elementary/Secondary (0-12) Co	lege (1-4or 5+)	ive kind of work done duri e. DO NOT use retired)	ing most of working		
-	The second	Completed	12th Grade	H	omemaker		Own Ho	ome
<u> </u>	be filed ntal Hygi od other event, II	a	17. Father's Name (First, Middle, Last)		18	8. Mother's Name (First, Middle,	Maiden Sumame)	
and		To B	John Collins			Myrtle	Range	
	2 should be filed within and Mental Hygiene. is marked other than eumatic event, Ite M.	-	19a. Informant's Name/Relationship (Type, Pri	nt) 19b. M	ailing Address (Street and	d Number or Rural Route Numb	er, City or Town, State,	Zip Code)
	trei		Mr. Wesley Berends		-	Forest Hill,	•	,
ā,	Hea Hea Hea Hem othe		20a. Method of Disposition		sposition (Name of crematory or other place)	Date	20c. Location - City or	Town, State
Бантто	ages ant of t: If i		1	I II OIII State	s of Faith	1/26/2004	Raltimata	Manuland
	it. P		21. Signature of Funeral Service Licensee	Journal		of Facility Schimunek		
מ	permit. Pages 1 and 2 should Department of Health and Mer Importent: If item 27 is marke eny injury or other treumatic once.		B. F. C.	1000				
			222 Rad Fotor the disease or complications	that caused the death. Do not		ir Rd., Baltimo		1236 Approximate
F	Physician		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition	e on each line.	,	assert as satisfactory as		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (acus a consequence of):				
	LAGITITIET	١.	Sequentially list conditions.					
	pi ji	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injurised separate	ue to (or as a consequence of):				
	and and trans	am	triat iritiated events					
Ö,	e ex		lesotting in death) cast	due to (or as a consequence of):				
	ate b hysic the b	Ilcal	d					
Ď:	ing p	Med	IF FEMALE:					
<u> </u>	th ce tendi	an/	23b. Was decedent pregnant 23c. If y	es, outcome of pregnancy Live birth 2 🗆 Fetal death	3 Ectopic pregnancy		23d. Date of del	
	e dea	Sic	1 ⊔ Yes 2 A(No	Pregnant at time of death	5 Other (specify)		Month	Day Year
د	I he law requires that the death certilicate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Med	9 U Onknown					
ກົ	gnec be de	þ	Part II. Other significant conditions contributing				obacco use contribute to	the cause of death?
Solus,	equir en si buld	P G	Chronic Obstra	active rulm	onary Dis	sease X	/es 2 □ No 3 □ Pr	obably 4 Unknown
ູ້	aw ra ts be 2 sh	Completed	Anemia			24a. Was		topsy findings available
ב כ	the te his	E				autop perfo 1 ☐ Yes	rmed? death?	completion of cause of
9	an: tifica tor, p	a	25. Was case referred to medical		26	6. Place of Death (Check only of		2010
>	ysici s cei direc	To B	examiner? 1 ☐ Yes 2 🗙 No Hospital	1 Inpatient 2 □ ER/Outpa	Other	4 ☐ Nursing Home 5 ☐ Resid		cifu)
5 i	eral eral			Date of Injury 28b. Tim	e of 28c. Injury at		now injury occurred	
5 :	ath.	읉	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injui		s 2 □No		
2	oy th	ü	3 Suicide 6 Could not be 28e	Place of Injury - At home, farm,	street, factory, office		Street and Number or Ru	ıral Route Number,
5 .	afte Dir	Certification:	4 Homicide	building, etc. (Specify)		City or Tov	vn, State)	
	spite		29a. Certifier 1 Certifying Physician:	To the best of my knowledge, d	eath occurred at the time,	date and place, and due to the	cause(s) and manner as	stated.
	1 24 to 1 24 t	Medical	(Check only 2 Medical Examiner: Or	the basis of examination and/o d manner stated.	r investigation, in my opini	ion, death occurred at the time,	date and place, and due	to the cause(s)
	To the Hospitel of Attending Priystcan: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	Me	29b. Signature and title of certifier	`	29c. License nu	umber	29d. Date signed (Monti	h, Day, Year)
	K		174 Shec	una!	no Doi	056477	1/22/24	
	10		30. Name and address of person who complete		pe, Print)		Maylot	
			Dr. Glenn Meininge			Drive Baltima	The Marylan	Maia ar
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Sparked		ac, aryon	- wor
	Registr		JANA L COUT /	/- /	1			

PRIGINAL

DHMH 17 Rev 1/2001

Berends, Ruth

		1- For State Registrar	ite of Maryland /	Depa		ealth and	d Mental Hy	_		01015
Physic	ian	Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year	3. Time of Death $425 A M$
/Med Exam	ical	James Bawow 4a. Fecility Name (If not institution, give street)	and number)		4b. City, Town, or I	ocation of De	-Javuar	4c. County	of Death	72/1
Exam	illei	Northwest Hospital C			Randalls	rowin		Ball	fimor	
Funera Directo		5. Social Security Number 6. Sex 216−28−6612 1 A 2 1 6. Sex	7. Age (In yrs. last I	birthday) Yrs.	If Under 1 Year Months Days		lin. 8. Date of Bin (Month, Da Nov 15,	th y, Year) 1930	9. Birthpla Count Mary	ace (State or Foreign y) Land
and		Usual Residence of Decedent 10a, State 10b, County	10c. City, To	wn or Lo	cation				10	d. Inside City Limits
Maryl f sho	Ď	MD Baltimore	Balt	imor	re					1 ☐ Yes 2 ☐ No
h the	Director	10e. Street and Number		-	10f. Zip Code			10g. Citizen of W	hat Count	ry?
23a c	al	6300 Liberty Road	APT 5		21207			U.S.		- 1-4/
ESITIMOTE, INSTYISTIC Z.I.Z.I.3-UUJO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event. The Medical Examinar must be published at	Completed by Funeral	1 Never Married 2 Married 1	as Decedent Ever in U.S. med Forces? MYes - 2 □ No res, Give aar or Dates:	ĺ	Was Decedent of His f Yes, specify Cuban 1 ☐ Yes 2 🗓 No		' (Specify Yes or No uerto Rican, etc.)	ŧ	e - America k, White, e : Whi	tc.
A I 3-U ithin 72 ho ie. Isen 'natur I Medical	npleted	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12)		(Give life.	dent's Usual Occupat kind of work done du DO NOT use retired)	tion uring most of	working	16b. Kind of Bu		
ied wi	So	12 17. Father's Name (First, Middle, Last)	3	Line		18 Mother's I	Name (First, Middle,			ications
d be fi	o Be	James Lewis Barrow					ia Richa		-,	
and 2 should leath and Men m 27 is marke	J.	19a. Informant's Name/Relationship (<i>Type, Pi</i> Jeoffrey Barrow			ng Address (Street ar Coxneck R					Code)
Baltimore, Maryland 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or any injury or other traumatic event. The Medical Example.		20a. Method of Disposition 1 Surial 2 Cremation 3 Remov 4 Donation 5 Other (Specify)	ai from State		sition (Name of matory or other place		Date 24/04	20c. Location - Woodlawr		
Departm Departm Importar any inju		21. Signature of Fineral Service Licensee	0.		Name and Address		oring Bye	rs Fune	ral D	irectors I
Physiciar /Medica		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death)	is that caused the death. Dise on each line. MCLIMONI G Due to (or as a consequence)		er the mode of dying	, such as care	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death
BOX 68 / 60, eath certificate be executed attending physician and for use as the burial-transit	cai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	SMAIL CILL (CLE) Due to (or as a consequence	ee atil.	ancer					
the death certifically the attending photomers as the	Physician/Medl	in the past 12 months?	yes, outcome of pregnancy Live birth 2 Fetal dea Pregnant at time of death Unknown		Ectopic pregnancy Other (specify)			23d. Dat Mor	e of delive	ry Day Year
That detail	þ	Part II. Dther significant conditions contribut	ing to death but not resulting	g in the u	ndertying cause give	n in Part I.	23e. Did t			a cause of death?
Of VITAI RECORDS, P. Physician: The law requires that rthis certificate has been signed b rail director, page 2 should be deta	Completed						24a. Was auto perfo	ormed?	rior to con leath?	sy findings available apletion of cause of
VITAL I sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?			Out		Death (Check only	оле)		
Of VITA Physician: rthis certific ral director.	2	1 ☐ Yes 2 ☐ No Hospit 27. Manner of Death 28	1 Inpatient 2 pc EH	Outpatier		4 🗆 Nursin	ng Home 5 ☐ Resi	dence 6 Cothe)
onding ath. or: Afte	Certification:	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work M 1 □ Y	? es 2 □ No		Street and Numb		Pouta Number
DIVISIO To the Hospitel or Attend within 24 hours after death To the Funerel Director: \(\) completely filled in by the f		4 Homicide determined 28	Place of Injury - At home building, etc. (Specify) To the best of my knowled			e date and n	City or To	wn, State)		
e Hos 24 hc e Fun etely I	edical	(Check only 2 Medical Examiner: (on the basis of examination and manner stated.							
To the within To the Comple	Me	29b. Signature and title of certifier	IO-MD		29c. License	number 50	7	29d. Date signed		
8		30. Name and address of person who comple	ted cause of death (Item 23)			rt Read	d Randal	/		
Regis	tate strar	31. Date filed (Month, Day, Year) JAN 2 7 2004	32. Registrar's Signature		gill 20	,			7	
DHMH 17 Rev	/2001		9	RIGIN	AL					

			1 - For State Registrar	State of Ma	arylan		artmen rtificate			and M	F	Reg. No.	004	0.86	
	Physicia	20	1. Decedent's Name (First, Middle, Las								2. Date of Dea	Day	Yeer	3. Time of Death	
	/Medic			mion							Johnar			7:03 M	
1	Examin	er	4a. Fecility Name (If not institution, give						Location o				ounty of Death		
			Bayvices Medical				If Under		If Under		O Data of Bird		1/A		
	Funeral		5. Social Security Number 6. Se	x ☐M 2(X)F		last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day May 9,	n V Year)	9. Birthp	lece (State or Foreign try)	
	Director		217–22–1157 Usual Residence of Decedent		78		l				May 9,	1925	Md		
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits	
	Mary in the	ţ	Md. N/A		В	altimo	re							1 XYes 2 ☐ No	
	1 the	rec	10e. Street and Number				10f. Zip	Code				10g. Citize	n of Whal Cour	itry?	
	h with	<u>اه</u>	1611 Pumphrey St	.				212	24			τ	JSA		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f ehow ampringury or other traumatic event, the Madical Extraction must be notified at ODGe.	by Funeral Director	11. Marital Status 1 M Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			Was Deced If Yes, spec		spanic Ori n, Mexican Specify:	gin? (Spi i, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, pecify: Whi	etc.	
Ò	2 ho	ted	15. Decedent's Ed	ucation		16a. Dece	dent's Usua	Occupa	ation	t of work	ing	16b. Kind	of Business/Inc	dustry	
2	hin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or	5+)	life.	kind of wor DO NOT us	e retired,)	COI WORK	ang				
7	gien gerth	Completed	8 yrs.			Sea	mstre	ss					hing		
P	al Hy	Be	17. Father's Name (First, Middle, Last)								(First, Middle,		mame)		
<u>X</u>	Ment Ment arked	2	Herbert Bynion								e Kować				
Maryland	2 shd and is m		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number or Rural Route Number, City or Town, St</i> 19c. Mailing Address (<i>Street and Number or Rural Route Number, City or Town, St</i> 1611 Pumphrey St. Baltimore Md. 21										Code)		
~	and lealth m 27 her t			SISU		lace of Dispo			St.					Chata	
Ore	ges 1 t of H If ite or ot		20a. Method of Disposition 1 XBurial 2 Cremation 3	Removal from State	0	emetery, crer	natory or of	ther place		Jan.	29,	Dunda		City or Town, Stete	
Ë	tant:		`4 □Donation 5 □ Other (Specify		Sac	red He			-		2004	Duriuc	ITK		
Baltimore,	permit Depar Impor any in		21 Signature of Funeral Service Lizen	I h		C	onnel 110 S	ly F	unera	al Ho	ome of I Rd. 212	Dunda] 222	Lk		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock/or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Par C Due to (or as	ne. 1 and	ic Ca		,	g, such as	cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death	
8760,	cate be executed physician and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last	c. Due to (or as											
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a' 9 □ Unknown	2 Feta	I death 3	Ectopic pro					230	I. Date of delive Month	ry Day Year	
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Ö	w requir	Completed									24a. Was	an la	24b. Were auto	psy findings available	
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Division of	i jir	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, et	ury - At he tc. (Specif	ome, farm, str	reet, factory	, office			28f. Location (S City or Тои		lumber or Rura	l Route Number,	
	To the Hospital within 24 hours a To the Funeral I completely filled	edical (29a. Certifier (Check only one) 1/2 Certifying Ph	ysician: To the best iner: On the basis o and manner st	f examina	wledge, death tion and/or in	h occurred vestigation,	at the tim in my op	e, date an pinion, dea	d place, th occurr	and due to the cred at the time, o	cause(s) and date and pl	d manner as st ace, and due to	ated. the cause(s)	
	withir To th comp	M	29b. Signature and title of certifier				290	. License	number		1		igned (Month,		
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	5		30. Name and address of person who de rice Hough	completed cause of c	death (Iten	1 23a) (Type,	Print)	lver	we.	Ba	ltimore				
	Sta Registr	9	31. Date filed (Month Rey, 20ar) 20	G4 32 Registr	ar's Signa	iture	00					1			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 23, Marie Bialozynski 2004 6:10 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Towson Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) October 6, 1946 Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F Director 212 46 5930 57 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show r then "naturel", or items 23s or 28s-f shov the Medical Examiner is not be notified at 1 ☐ Yes 2 ☐ No Maryland Baltimore Middle River 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 614 Oakdean Road 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 5-0036 "naturel", or 1 ☐ Yes 2 X No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2121 is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Accounting and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Menta! Charles Funk Mildred Jelinek ပ Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health al
Important: If Item 27 is
eny injury or other trau <u> William Bialozynski (husband)</u> 614 Oakdean Road Middle River Maryland 21220 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ② Cremation 3 ☐ Removal from State
4 ☐ Quantion 5 ☐ Other (Specify) Bayview Crematory Inc 1/26/2004 Baltimore, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 21. Signature of Funeral Service Licensee 23a. P. rt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician CANCER disease or condition resulting in death) .Una /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and I for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2 No 9☐ Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ■Unknown Completed peen 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No s certificate has lirector, page 2 s autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) ို 1 ☐ Yes 2 X No After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 Tes 2 No within 24 hours after death To the Funeral Director:, completely filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifie 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D25205 JANUARY 23, 2004 30. Name and address of person to completed dase of death (Item 23a) (Type, Print) W. A. Riley N. Charles St. Belto, md 21200 GBMC 670 1 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 7 2004 Registrar

ORIGINAL

		1 - For State Registrar	State of M	Maryland		artment rtificate			and M		giene		01610
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Funeral		5. Social Security Number 6. Se	x 7. /	Age (In yrs. I		If Under 1	Year	If Under	24 Hrs.	8. Date of Birt		9. Birth	plece (Stete or Foreign
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Marylan f show	lor	MD N/A			LTIMO								1 V Yes 2 □ No
r 28e	Director	10e. Street and Number			(L I II IO	10f. Zip C	ode				10g. Citizen of V	Vhat Cou	intry?
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rs att	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 [If Yes, Give Year or Date:			1 □ Yes 2	No.	Specify:			Specify	:	WHITE
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2 should be filed within 72 hours alt and Mental Hygiene. is marked other than "natural, or raumatic event, the Medical Exami	F	19a. Informant's Name/Relationship (T	ype, Print)		19b. Mailir	ng Address (Street e	nd Numbe	er or Rura	Il Route Numbe	er, City or Town,	State, Zi	p Code)
and 2 saith a n 27 is		JACK BERMAN / SO	N	,		-		COURT			MORE, M		
Peges 1 and nent of Health int: If item 27 iry or other ti	1 - 24	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from Sta	te ce	emetery, crer	sition (Name matory or oth	er place				20c. Location -		
그 돈 큰 글		`4 Donation 5 ☐ Other (Specify)	HEE		OUNG M				2004	WOOD		
permit. Depart Import. eny inj		21. Signature of Funeral Service Licens	II seed			Name and			50		ISON & B		, INC. MD 21208
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g Phy er this seral o	 	27. Manner of Death	28a. Date of 1 (Month,		28b. Time o		c. Injury Work				now injury occurr		(9)
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or Att	rtific	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury 28b. Time of Injury M 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred											al Route Number,
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ne Hos 124 h ie Fur ietely	edical	(Check only 2 Medicel Examone)		s of examina									
To th withir To th comp	Me	29b. Signature and title of certifier	1	. ^				number	00		29d. Date signed	(Month	, Dey, Year)
D		1	1	(1)			1)	27	169		1123/		
10		30. Name and address of person who o	comptered cause	f death (Item	23a) (Type,	Print)	s C	(4	10.	·TA	02 A	. 2	21208
Sta	10	31. Date liled (Month, Day, Year)	32. Reg	istrar's Signa	ture	, 9 ,	9		work	× (/		W1	

DHMH 17 Rev 1/2001

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ORIGINAL

		For State Registrar	State of Marylar	•	nt of Health and Mate of Death		iene2 0 0 le	01819
		Decedent's Name (First, Middle, Last)				2. Date of Deat	h	3. Time of Death)
Physicia	an	Occo P	Conu	FORD		Month	Day Year	9:35PM
/Medic		4a. Facility Name (If not institution, give str			y, Town, or Location of Death	9.17	4c. County of Death	
Examin	er	Busil Pun	Assistan	Living	Boi DiR		HAPE	FARA
Formula		5. Social Security Number 6. Sex	7. Age (In yrs.		er 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Birth	place (State or Foreign
Funeral Director			M 200 F	75 Yrs. Month	s Days Hours Min.	Alonth, Day,	28 Mac	(1/2 NA
		Usual Residence of Decedent						7,000
ylanc		10a. State 10b. County	10c. Ci	ty, Town or Location				10d. Inside City Limits
Mar I-1 sh	ţō	MN HARFOI	00	JARR	ETTSVILLE	5		1 ☐ Yes 2 No
h the	lrec	10e. Street and Number	1	10f. 2	Cip Code	1	0g. Citizen of What Cou	ntry?
h wit	Funeral Director	3528 Glen 00	1 K DC.		21084.		USA	
deat	ner		2. Was Decedent Ever in U Armed Forces?.	I.S. 13. Was Dec	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
with after death with the Marylan rail, or items 23s or 28s-1 show	臣	1 Never Married 2 Married	1 ☐ Yes 2 (No If Yes, Give		2 No Specify:		Specify: 1.1/a	1/0
72 hours after death with the Maryland 72 hours after death with the Maryland naturel; or items 23s or 28s-f show area Examiner in ust be notified at	1 by	3 Widowed 4 □ Divorced	Year or Dates:		7		W	1/72.
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s 1 and 2 should be filed within 72 hc if Health and Mental Hygiene. Item 27 is marked other than "naturallo event, the Mudical		19a. Informant's Na e/Relationship (Tyo	d, Print)	19b. Mailing Addre	ss (Street and Number on Run	al Route Number	City or Town, State, Zi	(Code) 2100 4
1 and Health Hem 27 Sther tr		Linda Miller	205	130d8 (c	ien cak Di	Date ARA	20c. Location - City or T	G III
permit. Pages 1 a Department of Hec Important: If Item any Injury or othe		20a. Method of Disposition 1 ■ Burial 2 ■ Cremation 3 ■ Re	1 ^	Place of Disposition (No cemetery, crematory of		Date	0	own, state
Pag ment ant: ury		* 4 ☐ Donation 5 ☐ Other (Specify)	I PA		EMETERY 2-1	2-2004	PARKVILLE	ms.
permit. Pages Department of Important: If It any Injury or o		21. Signature of Funeral Service Licensee	1	22. Name	and Address of Pacility	Timori	- 0	234
70E # 9		Mullily V. 3	Withing	GUANS		PEL SEC	x HARFOR	DRD.
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ath ce	an/l	23b. Was decedent pregnant in the past 12 months?	lc. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		pregnancy		23d. Date of deliv Month	ery Day Year
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nysic nysic	2	1 ☐ Yes 2 X No	ospital: 1 ☐ Inpatient 2 ☐	☐ER/Outpatient 3☐	DOA Other: 4 Nursing Ho	ome 5 Reside	ence 6 SOther (Speci	W) Assisted
ng Phy Ter this		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe ho	w injury occurred	Facions
Attending or death.	atle	2 Accident investigation		М	1 ☐ Yes 2 ☐ No			2009
rerde recto	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, street, fact	ory, office	28f. Location (St City or Town	reet and Number or Run n, State)	al Route Number,
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical				ed at the time, date and place, on, in my opinion, death occur			
o the o the omple	Med	29b. Signature and title of certifier			29c. License number		9d. Date signed (Month,	
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		30 Name and address of seven who con	moleted cause of death (Ite	m 23a) (Type Print)	MEEN	CIA	UD EUN	- 07
10		30. Name and address of person who cor 9105 PRANKLIN	SQUARE A	RIVE B	ALTIMORF.	MIN	21237	
St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature	///////////////////////////////////////		-1-31	
Regist		IAN 9 7 2004	M.	21 Angelle	,			

			1 - For State Registrar	-	epartment of Health and Certificate of Death	Mental Hygien	C U U 4	01050
k	Physici /Medic		1. Decedent's Name (First, Middle, Last)	e D. Cran	e	2. Date of Death	24 2004	3. Time of Death
) j	Examir		4a. Facility Name (If not institution, give st Stella Mari 5. Social Security Number 6. Sex	7. Age (In yrs. last birth	4b. City, Town, or Location of Deat		Baltina	ore Co.
	Funeral Director		215-10-9706 1 Usual Residence of Decedent	M 20 F 92 Y	s. Months Days Hours Min.	(Month, Day, Yea	il ma	lace (State or Foreign try)
	death with the Maryland me 23a or 28e-f show court be notified at	ector	Maryland Baltime	The Co. Tim	drium			0d. Inside City Limits 1 ☐ Yes 2 TÑo
	e 23a or 2	Funeral Director	2300 Dulaney	Valley Rd. 2. Was Decedent Ever in U.S.	10f. Zip Code 2/093	1	Citizen of What Count	1
	ours after de al', or item Exercirer	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Amed Forces? 1 Yes 2D No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes Specify: 	to Rican, etc.)	Black, White, e	
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ylanu z	should be filed nd Mental Hygi marked other umatic event, I	To Be Co	17. Father's Name (First, Middle, Last) Alexander	Dominick		me (First, Middle, Maide	Broki	15
, Mar	and 2 sho lealth and m 27 is m her treum		19a. Informant's Name/Relationship (Typ) MC DAVIA DOMI	nick (nephew) 1:	Mailing Address Street and Number or Ri 206 Regester H	hre. Balt	0. MD. 2	1239
Saltimore	permit. Pages 1 Department of H Important: If Ite any injury or ot		20a. Method of Disposition 1 Surial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	moval from State Du aney	Disposition (Name of crematory or other place) Valley Mem. Gar.	1.780 -	Location - City or Tov	, mD
Da Da	Depar Impor any ir	10.7	Jeppen Fil	Jany Se.	PEACETY ATTEMENT	tives fune	MO 2	matia, Certer 1093 Approximate
	Physician /Medical		23a. Fa/11. Enter the disclase, or combile shock or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of)	ic Ovaria	n Cano		Interval Between Onset and Death
	Examiner per lisus	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence of)	:			
9/00,	cate be executed physician and the burial-transit	dicai Exa	resulting in death) Last	Due to (or as a consequence of)	:			
. Box o	death certific e attending p ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. If yes, outcome of pregnancy 1 Urve birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of deliver Month	ry Day Year
cords, P.	requires that the reen signed by th hould be detache	by	Part II. Other significant conditions cont	ibuting to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobacco	use contribute to the	e cause of death?
•	:: The law re cate has bee ; page 2 sho	Completed				24a. Was an autopsy performed? 1 ☐ Yes 2 🔼 N	death?	psy findings available apletion of cause of 2 No
on or vital	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to the funeral director, page 2 to the funeral director.	ition: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	spital: 1 Inpatient 2 EP/Outp 28a. Date of Injury (Month, Day Year) 28b. Tin Inju	atient 3 DOA Other: 4 Nursing H	ath (Check only one) lome 5 Residence 28d. Describe how inju		1
DIVISION	al or Atter s after dea il Director ed in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street a City or Town, Sta	und Number or Rural te)	Route Number,
	he Hospit in 24 hour he Funers pletely fille	edical	29a. Certifier 1 (Check only one) 1 (I ← Certifying Physical Examine one)	cian: To the best of my knowledge, or: On the basis of examination and/orand manner stated.	death occurred at the time, date and place or investigation, in my opinion, death occu	o, and due to the cause(irred at the time, date ar	s) and manner as sta nd place, and due to	ited. the cause(s)
	vith Tot com	Σ	29b. Signature and title of certifier Methods	Wonght	29c. License number 0 5 2	740 J	ate signed (Month, D	26 h, 2004
	5		30. Name and address of person who com	t, 2300 Dul	ope, Print) valley Ra	oad Timo	mon M	D21093
I	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	roll 1			

			For State Registrar		t Marylar		artmen rtificate				1ental Hy	Reg. No.	004	01851
Phy	sicia	_	Decedent's Name (First, Middle	Norman E.	Carlso	n					Januar		2004	3. Time of Death 4:41 Р м
	ledica amine		4a. Facility Name (If not institution				4b. City,	Town, or	Location	of Death			unty of Death	
LAC	21111111		Charlestown Ca	re Center			Ca	tons	ville	е		E	Baltimo	re
Fune Direc			5. Social Security Number 022 07 5482	6. Sex 1 □ X0M 2 □ F	7. Age (In yrs. 89	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Nov 25	th ly, Year) , 1914	9. Birth Cou Mass	plece (State or Foreign http:) achusetts
uyland s how	1		Usual Residence of Decedent 10a. State 10b. County			ty, Town or Lo								10d. Inside City Limits
he Ma	allie	ecto	MD Bal	timore	C	atonsv		0-4-				10- Ciri-		1 ☐ Yes 21 No
with t	0.00		719 Maiden Cho	ice Tane 1	HR533		10f. Zip	1228					of What Cou Lted St	•
death ms 23		Funeral Director	11. Marital Status	12. Was Dece	edent Ever in U	.S. 13.				igin? (Sp	ecify Yes or No Rican, etc.)	₃ - 14.	Race - Ameri	
be filed within 72 hours after death with the Maryland tal Hygiene.	MUUUN		1 ☐ Never Married 2 【※ Marriad 3 ☐ Widowed 4 ☐ Divorced	Armed For ied 1 (2) Yes If Yes, Giv Year or D			ir ves, spec 1 ☐ Yes 2		Specify:		rican, etc.)		Black, White, pecify: Wh	eic. ite
72 ho	ilea	Completed by		t's Education st grade completed)		(Give	dent's Usua kind of wor	k done o	turina mos	at of work	ing	16b. Kind	of Business/In	ndustry
A I A I D-0050 od within 72 hours aft giene. er than "natural", or	e Me	du l	Elementary/Secondary (0-12)	College (1	I-4or 5+)	Fire	DO NOT us	e retired				Fire	Protec	tion
A 50 P	in t		17. Father's Name (First, Middle,			rire	PLOCE				e (First, Middle	L		.01011
nd 2 should be filed within the and Mental Hygiene.	atic eva	To Be	Carl Emil Carl	son					Emil	y Mai	rianna	Johans	sson	
VICII d 2 sh h and 7 ls m	traum		19a. Informant's Name/Relations Anita K. Carls			1	-				al Route Numb	-		MD 21228
Healt Healt	other	Į.	20a. Method of Disposition	OII/ WITE	20b. F	Place of Dispo	sition (Nan	ne of	1		Date		ion - City or T	
Pages ent of	20		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Siate	etro Cr		-		1–26	-2004	Cator	nsville	e, MD
Dattilliole, Intal yidi permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked	any inju		21. Signature of Funeral Service		M0104									ly FH Inc. MD 21043
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that of	aused the deal								3 010, 7	Approximate Interval Between
Physic	ian		Immediate Cause (Final disease or condition	met	co loto	ctic	l h	100	7					Onset and Death
/Medi Exami	_		resulting in death)	Oue to	(or as a consec	juence of):	<u> </u>	*****						1.001
LAGIIII		5	Sequentially list conditions, if any, reading to immediate	b. — Due to	(or as a sonew	luarios of):								
petn T	ansil	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	(·								
cate be executed	burial-tr	Ical Exa	resulting in death) Last	cDue to	or as a consec	quence of):								
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death cer	hed for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐Live t	come of pregna pirth 2 Feta pant at time of coown	ildeath 3 [Ectopic pro					230	. Date of delive Month	ery Day Year
	9	<u>۾</u>	Part II. Other significant condition	ons contributing to d	eath but not res	ulting in the u	nderlying ca	ause give	en in Part	l.	1	obacco use Yes 2 1		he cause of death?
The lar	page 2 should	Completed		h to the Teach.							24a. Was auto perfo 1 □ Yes	an 2 psy pmed? 22 No	4b. Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of
VII. This icien: The certificate	ctor, p	Bec	25. Was case referred to medica examiner?						26. Place	e of Deat	h (Check only			
OI VILA Physicien:	al dire	ို	1 ☐ Yes 2 ☑ No			ER/Outpatier			4 NI	-	me 5□Resi			ý)
Off Of Vital Iding Physicien: Ih. After this certifica	funera	tlon:	27. Manner of Death 1. Natural 5 Pendir Accident investi	ig .	th, Day Yeer)	28b. Time of Injury	M 2	8c. Injury Work	rar ⟨? Yes 2□		28d. Describe	now injury o	ccurred	
or Attender the deal	Ĕ	Certification:	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At hing, etc. (Speci	ome, farm, str fy)					28f. Location (City or To		lumber or Rura	al Route Number,
To the Hospital within 24 hours a To the Funerel I	completely filled in by	edical Ce	29a. Certifier 1 Certifyir (Check only one) 1 Medicel	ng Physician: To the Examiner: On the b	best of my kno asis of examina	owledge, deat ation and/or in	h occurred vestigation,	at the tim	e, date ar	nd place, ath occur	and due to the red at the time,	cause(s) an date and pla	d manner as s	tated. o the cause(s)
o the vithin of	omple	Mec	29b. Signature and title of certifie	-			29c	. License	number			29d. Date s	igned (Month,	Dey, Year)
- s =	,		Indimon	/			-	30	989			TOO	nni	PF PMH
o l	1		30. Name and address of person	who completed caus	se of death (Iter	п 23а) (Туре,	Print)	_				الشايد	me.	12004
X	' '		MylaM Carps	Oter M	D 711 I	Maid	20,0	hoi	CEL	7	Cathoe	ville	MD	
Re	Sta gistra		31. Qae filed (Month, Day, Year)	004	legistrar's Sign	TUI B	ist.							

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Peter C. Collins 21, 2004 4c. County of Death January /Medical 6:46 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Towson Baltimore Greater Baltimore Medical Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6 Sev **Funeral** 1 M 2 F 80 Aug. 7 1923 Wisconsin **Director** 394-18-7983 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iteme 23s or 28s-f show f Health and Mental Hygiene. item 27 is marked other than "natural", or iteme 23a or 28a-f ehov other traumatic event, the Macilical Examinar coust be natified at 1 ☐ Yes 2 No MD Baltimore Timonium Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 404 Ivy Church Rd. 21093 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 → Yes 2 → No If Yes, Give Year or Dates: 143-146 permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 21 is marked other the any injury or other traum—" 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3€ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Actor Entertainment 12 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Dr. Clarence Collins Phoebe Shierk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12850 Stone Eagle Rd., Phoenix, MD 21131
of Disposition (Name of Date 20c. Location - City or Town, S Stacy Collins O'Conor/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Balto, Wash, Crematory 1/27/04 Laurel, MD 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Appropriate Course (First) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto for as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760. use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 1 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 3 Probably 4 Unknown 1 Yes 2 No page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 2 Yes 2 □ No autopsy performed? 1 Yes 2 🗆 No hronic 25. Was case referred to medical examiner? the funeral director. 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ★ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funerel Directo completely filled in by ti Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 5 30. Name and address of person who completed use of death (Item 23a) (Type, Print) 21204 M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

		1 - For State Registrar	State of Marylar	nd / Depa		Health and I	Mental Hyg	_	04	010=0
		1. Decedent's Name (First, Middle, Last,					2. Date of Deal	lh Day	Year	3. Time of Death
Physic /Med		ALFRED		416	ERE		JANUAR	y 22	2004	2145 M
Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Deatl	h		y of Death	
4		JOHNS HOPKING			BALTIN			N/A		
Funeral Director		211-22-1119	7. Age (In yrs. 75	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day) March6	Year) ,1928	9. Birthp Cour MC	lace (State or Foreign try)
Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Md. Baltimon		ty, Town or Lo		 ·			1	0d. Inside City Limits 1 ☐ Yes 2 XNo
with the	Funeral Director	10e. Street and Number 8204 Watersedge I	Rd.		10f. Zip Code 212	222	1	0g. Citizen of		ntry?
idryidilid Z 1 Z 13-UU30 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene is marked other than "naturel", or Itams 23e or 28a-f show aumetic event, tra Medical Exartal or market critished	þ	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Ra Bia	ce - Americ ick, White, fy: Whit	etc.
Mar y Idilia Z I Z I 3-0030 d 2 should be filed within 72 hours af th and Mental Hygiene. ?? is marked other than "naturel", or traumatic svent, tra Mudical Exatt	Completed	15. Decedent's Edu (Specify only highest grad	cation e com <i>pleted)</i> College (1-4or 5+)	(Give life.	DO NOT use retire	during most of wor	rking	16b. Kind of E	Business/Inc	dustry
A la ed wi	S	7 yrs.		Sh	nearman			Stee		
क व व ठ ड	To Be	17. Father's Name (First, Middle, Last) Gerlamo Cicere				18. Mother's Nar Concet	ne (First, Middle, M ta Mona		me)	
7 5 € 5 E		19a. Informant's Name/Relationship (Ty Grace Cicere	рө, Print) Wife		_	and Number or Ru ge Rd. Di				Code)
Dalfilliore, IN Department of Health Important: If item 27 i any injury or other tre pne.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		Place of Dispo	sition (Name of		Date	20c. Location Owings	- City or To	
permit. Pages of Department of himportant: If ite sny injury or of once.		21. Signature of Funeral Service Licens		(1) C_0^{22}	Name and Addre	ess of Facility uneral Ho rs Point	ome Of Du	ndalk		
Physician		23a. Part1. Enter the disease or compleshock, or heart failure. Est only of Immediate Cause (Final disease or condition	ications that caused the deat ne cause on each line.	h. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death 24 HOURS
/Medical Examiner		resulting in death) Sequentially list conditions,	CI GPINAL Due to (or as a consequence)	- COR	D LESI	al				24 HOURS
ite be executed hysician and he burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq							
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uires that the de n signed by the a	þ	Part II. Other significant conditions con PARKINGONS		ulting in the ur	nderlying cause giv	ven in Part I.				e cause of death?
The law ate has be page 2 s	Completed						24a. Was ar autops perform 1 Yes 2	y ned?	Were autopprior to condeath?	osy findings available npletion of cause of 2 .No
vician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:		Oth		th (Check only on		_	
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al or Attanding after death. I Director: After d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre			28f. Location (Str City or Town	reet and Numb , State)	ber or Rura	Route Number,
To the Hospital or Al within 24 hours after or To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Physical Certifying Physical Call Examination (Check only one)	sician: To the best of my knoner: On the basis of examina and manner stated.	owledge, death	n occurred at the tirvestigation, in my o	me, date and place opinion, death occu	, and due to the ca rred at the time, da	iuse(s) and ma ite and place,	anner as sta	ated. the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier	f was		29c. Licens		1	d. Date signe		
		I stule 9 Dec	dmo		RES	-100	14	ANUARY		
1		30. Name and address of person who co	PKING HOSPITAL	L TONZ	,	0 NO2TH V	NOLFE STO	LCET B	MIARYL	0125, AND 21287
St Regist	ate trar	31. Date filed (Month PM Year) 7 20	04 32. Régistrar's Signa	iture	seek s					

State of Maryland / Department of Health and Mental Hygiene?

		1 - For State Registrar	State of	of Mar	yland /		artment <i>rtificate</i>				dental H	ygien Reg. N	100		
- ·		1. Decedent's Name (First, Middle, L.	ast)								2. Date of D		ay Yee		. Time of Death
Physici /Medi		Ra1			Cast	<u>eel</u>					Januar		4, 2004		3:15 ₽ ^M
Examir		4a. Fecility Name (If not institution, gi	ve street and nu	Vant	age		4b. City, T			of Death		4	c. County of De		
		vantage House	≘/ Point Sex	Roa	ld In yrs. last	hirthohu	If Under		umb	1a er 24 Hrs.	8. Date of B	irth	Howa		(State or Foreign
Funeral Director		259-16-2284	1 M 2 □ F	7. Age (i	85	Yrs.	Months	Days	Hours		NOV 11	ay, Yea	918 Ge	Country)	(State or Foreign
1 5		Usual Residence of Decedent							1		11101 11	-, -	710 100		
nylan show	_	10a. State 10b. County		1	Oc. City, T		ocation								Inside City Limits
Ba-f s	Directo	Maryland Howard			Colum	ıbıa	1					1 40: 6	No. of hall a		1 □Yes 2∏No
with ti	吉	10e. Street and Number 5400 Vantage Poi	nt Poad	#11	1 3		10f. Zip	044				US ₂	Citizen of What A	Country	
eath ne 23	Funeral	11. Marital Status	12. Was Dec			13.			ispanic C	Origin? (Sp	ecify Yes or N		14. Race - Ar	nerican I	ndian,
r Hen	F	1 Never Married 2 Married	Armed F	orces?	194	1_	If Yes, speci	rfy Cuba	ın, Mexic	an, Puerto	Rican, etc.)		Black, Wi		
ral', o	ρ	3 Widowed 4 Divorced	If Yes, G Year or D	ive Dates:	194		1□ Yes Ž	X No	Specif	y:			Specify:		White
72 ho	Completed	15. Decedent's l (Specify only highest g	ducation rade completed)		(Give	dent's Usual	k done i	during mi	ost of work	ing	16b.	Kind of Busines	ss/Indust	ry
han '	m D	Elementary/Secondary (0-12)	College ((1-4or 5+)	E	xecu	Medi	ASSI	star Dire	it to	the	Vet	erans Adr	minist	tration
Hygie Hygie ther t		17. Father's Name (First, Middle, Las	st)			HILCI	ricar	car			e (First, Middi				
d be ental ked o	To Be	Joseph Casteel							Ves	sta F	uller				
should Mark	F	19a. Informant's Name/Relationship	(Type, Print)		- 1	19b. Maili	ng Address	(Street	and Num	ber or Rur	al Route Num	ber, City	or Town, State	, Zip Cod	de)
alth a		Elva L. Casteel	/Wife			5400	Vanta	age	Poir	nt #1:	113 (Colu	mbia, M	D 2	1044
of He of He fiterr		20a. Method of Disposition 1 □ Burial 2 ☑Cremation 3	□ Bemoval from	State	20b. Place ceme	e of Dispo	osition (Nam matory or ot	ne of ther plac	;e)		Date	20c.	Location - City	or Town,	State
Pag ment ant: h		'4 Donation 5 Other (Spec		Julia	Metr	o Cr	emato	ry I	nc.	1-2	6 - 04	Ва	altimor	e, M	D
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If ten 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination notified at once.		21. Signature of Laweral Service liquid	regorch	nik		2	2. Name and Cremate 299 Fi				of MD.	Ind	c. ore. MD	21	228
	Г	23a. Part1. Enter the disease, or conshock, or heart failure. List only	nolications that	caused th	e death. [Do not en							,	Ap	proximate erval Between
Physician		Immediate Cause (Final disease or condition			pne	omo	rice							On	set and Death
/Medical		resulting in death)	Due to		nsequen		/		,	- /					7.0.1
Examiner	L	Sequentially list conditions,	b				batruck	148 1	UF	M LEAR	e			10	youn
ed sit	olu	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(OI as a C	consequen	CB OI):									
al-tra	Examiner	that initiated events resulting in death) Last	c	(or as a c	consequen	ce of):		-	-					-	
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tificat ng phy as th	Medi														
th cer tendir r use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou 1□Live		pregnancy □ Fetal de		□Ectopic pre	egnancy	,				23d. Date of o	lelivery Day	/ Year
e dea the att	sici	in the past 12 months? 1 Yes 2 No 9 Unknown	4□Preg 9□Unkr		ne of death		Other (spe						MOUTH	Day	/ Teal
hat the		Part II. Other significant conditions	contribution to	death but i	not resultin	o in the I	inderlying ca	ALISA OIV	en in Par	7	23e Did	tobacco	use contribute	to the ca	ause of death?
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ysicia s cert direct	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital:	Inpatient	2 ER	/Outpatie	nt 3 🗆 DQ	A Oth	00				6 □Other (Si	pecify)	
g Physical Ser this		27. Manner of Death	28a. Date	of Injury	(ear) 28	b. Time o	of 28	8c. Injun	y at		28d. Describe	how in	jury occurred	,	
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r Attu	tiffe	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	280. Plac	e of Injury ding, etc.	· At home (Specify)	, farm, st	reet, factory,	, office			28f. Location City or T	(Street own, Sta	and Number or ite)	Rural Ro	ute Number,
urs af						11.				-					
To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Certifying I (Check only one) 1 Medical Ex	aminer: On the	ie best of i basis of ei nner state	xamination	age, deat and/or in	in occurred a nvestigation,	at the tin in my o	ne, date pinion, d	and place, eath occur	and due to th red at the time	e causei e, date a	(s) and manner nd place, and d	as stated ue to the	1. cause(s)
To the within To the comple	Me	29b. Signature and title of certifier	ma /	77			29c.		e numbe			29d. E	ate signed (Mo	nth, Day	, Year)
->- x\		1 2000	Mulls	13 /	MO			02	266	15		Ja	nuary	26.	2004
16		30. Name and address of person wh			th (Item 23	За) (Туре	, Print)		1	21	MO		,	- ,	
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Eleanor Carlson 8:35 P M Doris J<u>anuary</u> 25, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Chesapeake Arnold Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 TF DEC 26, 1917 Director 540-01-9421 86 Oregon Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Severna Park Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21146 5 St. Andrews Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White If Yes, Give Year or Dates: Snecify: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) h and Mental Hygiene.
7 Is marked other than ireumatic event, Inc. M. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Elston Ella Bones ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 la 5 St. Andrews Road Richard Carlson/Son Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or of once 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Metro Crematory Inc. 1-26-04 Baltimore, MD 21. Signature Funeral Service Licensee

Edward A. Gregorchik permit. Cremation Society of MD, Inc. 299 Frederick Road Baltimore, 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760. by Physician/Medical attending p as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy certificate ha 1 Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 1 ☐ Yes 2 No this After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death

1 Natural

2 □ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel (To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) D41955 1-26-04 MillersvilleMD Highway MO ecca 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 27 Registrar

			1 - For State of M. State of M. Registrar		artment of Health and rtificate of Death		ene () () () () () () ()	01056								
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Gloria	Dicus		2. Date of Death		3. Time of Death 5:15A M								
	Exami		210 01	Park e Roland e (In yrs. last birthday) 7 Yrs.	4b. Cily, Town, or Location of Dea	s. 8. Date of Birth (Month, Day,	4c. County of Death N/A N/A 9. Birthplace (State or Foreign Country)									
	Director wow mpail		Usual Residence of Decedent 10a. State 10b. County Maryland n/a	10c. City, Town or Lo	10c. City, Town or Location Baltimore		Feb. 11, 1936 Mary									
	ath with the 23e or 28a uat be noti	Funeral Director	10e. Street and Number 1009 Rectory Lane		10f. Zip Code 21211	10	g, Citizen of What Cour	ntry?								
9800	within 72 hours after deeth with the Maryland ene. then "natural", or Items 23e or 28a-f ehow ha M. dical Examinar must be notified at	by	11. Marital Status 1 Never Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes, Give Year or Dates:	No	Was Decedent of Hispanic Origin? (f Yes, specify Cuban, Mexican, Pue 1 □ Yes 3√√No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Americ Black, White, Specify: W									
Maryland 21215-0036	d within 72 ha giene. or then "natu the M. cical	To Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5)	(Give life.	dent's Usual Occupation kind of work done during most of w DO NOT use retired)	orking	6b. Kind of Business/Inc									
ryland	should be filed nd Mental Hygi marked other imatic event, I		17. Father's Name (First, Middle, Last) Frederick Davis 19a. Informant's Name/Relationship (Type, Print)				aiden Sumame) Y									
Baltimore, Ma	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23e or 28a-1 ehow any injury or other traumatic event, the Mucical Examiner must be notified at once.		Raymond Dicus Husband 20a. Method of Disposition 1 Burial 200 Cremation 3 Removal from State 4 Dongton 5 Other (Specify)	20b. Place of Dispo cemetery, crem Baltimor	P Rectory Lane Basision (Name of natory or other place) e-Washington	altimore, Date 20	Maryland 21 Oc. Location - City or To	.211 wn, State								
Balti	Departir Departir Importe eny inji		21. Significate Funeral Service Icons in Power 23a. Part1. Enjoy the disease, or complications that caused shock, or learn failure. List only one cause on each line.		burgee-Hanss-S	eitz Fun	Laurel, M eral Home more, MD									
8760,	Cate be executed whysicien and physicien and physicien and the burial-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events a. Due to (or as	a consequence of): a consequence of): a consequence of): Butter	Comcer in dealton and tal abd by I Solpmes	the metal further strecting	stem	Onset and Death								
O. Box 6	The law requires that the death certific lie has been signed by the attending p lage 2 should be detached for use as	ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	2 Fetel death 3	Ectopic pregnancy Other (specify)		23d. Date of deliver	ry Day Year								
Division of Vital Records, P.O.	w requires that is been signed by should be deta	Medical Certification; To Be Completed by Physician/Me	ted by Ph	eted by Pt	eted by Pr	ted by Pr	ted by Ph	ted by Ph	ted by Ph	eted by Pr	Part II. Other significant conditions contributing to death be	at not resulting in the un	iderlying cause given in Part I.	1	cco use contribute to the	. /
	ng Physician: ifter this certifica ineral director, p		Hypertenson Hypertenson 25. Was case referred to medical		26 Place of De	24a. Was an autopsy performe 1 Yes 25 ath Check only one	death?	osy findings available apletion of cause of 2 No								
			ToB	ToB	examiner? 1 Yes 2 No Hospital: 1 Inpatie 27. Manney of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be	28b. Time of (Year) Injury	Other: 4 Nursing I 28c. Injury at Work? M 1 Yes 2 No	dome 5 Residence 28d. Describe how								
2	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4 Homicide determined 200. Fracts of inju-building, etc 29a. Certifier (Check only 2 Medical Examiner: On the basis of	iry - At home, farm, stre	occurred at the time, date and place	City or Town, S	se(s) and manner as eta	and a								
ı			29b. Signature and title of certifier	mD	29c. License number D 3iy 6 y		Date signed (Month, D	Day, Year)								
	Sta Registr	-	30. Name and address of person who completed cause of de Strong Strong A - HAS Hoo (31. Date filed (Month, Day, Year) JAN 2 7 2004		*	St Sim	tt 308 13	21201								

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2004 **Physician** 10:06 AM Raymond Elmer Dearchs January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore St. Joseph Medical Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Days 1921 82 Minnesota 410-14-0038 Director Usuel Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits sr than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director Maryland Baltimore Towson 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 1403 Malvern Avenue 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Madical Examination. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify White 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Building Contractor Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Claude Elmer Dearchs Margaret Hofius 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1403 Malvern Avenue Towson. MD21204 Raymond A. Dearchs/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 1-24-04 Baltimore, MD Other (Specify) ⁴ 4 □ Donetion Fidward A. Gregorchik ^{22 Name and Address of Facility} Cremation Society of MD, Inc. 299 Frederick Road Baltimore, 21. Signature of Fe Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 5 **Physician** 422 /Medical Due to (or as a consequence of): Examiner UBSTR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed mem Howic Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Tyes 2 □ No 3 Probably 4 □Unknown page 2 should Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 2□ No UBSTRUCTU 1 Yes 2 **N**0 1 Tyes Hospitel or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 PER/Outpatient 3 DOA Certification: To neral Director: After this filled in by the funeral dir 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours To the Funeral 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier D 28812 January 23, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vincent A. DiPietro, MD 7801 York Road, Suite 102 Towson, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 7 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3 Time of Death Month Physician orse anular /Medical County of Death 4b. City, Town, or Location of Death 4c. 4a. Facility Name (If not institution, give street and number) Examiner ikesville larna Kd If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 M 2 F Director Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene.
Item 27 Is marked other then "naturel", or Items 23s or 28s-1 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Baltimore Kesville 1 Yes 2 PNo Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2953 USA 1209 Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? / Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 PNo If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 2 1 No Specify: Black Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Idoare 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) To Be **Worsey** Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9a. Informant's Name/Relationship Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State ō <u>=</u> 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If eny injury or Cremator 21. Signature of the meral Service Licensee 21289 P. March Flit 240 Fredhilton Pass Balto, mo Approximate Interval Between Onset and Death Part. Intertual disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Fonte Immediat Fause (Final ocarchal Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical as the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 5 Other (specify) P.O. been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No this certificate has al director, page 2 1 Yes Physician: 25. Was case referred to medical examiner?

1 Yes 2 □ No To Be 26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) within 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: or Attending 1 Natural 2 ☐ Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide To the Hospital t 🗌 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Hondren MI D000 76 Cuossan Vanualy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DUNDALK AVE MD MD スノンシュ J. CROSSAN O'DONOUAN 2112 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 27

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Examin			a. Facility Name (If not institution, give street and number) Gilchrist Center Social Security Number 6. Sex 7. Age (In yrs. last birth			last birthday)	Towson If Under 1 Year	r Location of Death If Under 24 Hrs.	8. Date of Birt	4c. County of Deal Baltimo	
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ral', or Items 23a or 28e-f show Examiner must be notified at	by Funeral		Armied 2 Marned 1 Mere 2 Marned 2 Marned 2 Marned 1 Mere 2 Marned 1 Mere 2 Mere 3 Mere		2 TVI No	in U.S. 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☒ No Specify:			ecify Yes or No- Rican, etc.)	oncan Indian, e, etc. White	
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c event, E	Be	17. Father's Name	(First, Middle, Buck	Last)			Teacher		e (First, Middle, May	Educati Maiden Sumame) Porter	LON
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ant: If item ary or othe		20a. Method of Disp	oosition Cremation	3 □Removal from S	20b. F	Place of Dispo	sition (Name of natory or other place emetery	1 (90)/2004	20c. Location - City or Phoenixvi	
Imrorts any inju		21. Signatura of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204									
sician and edical miner	al Examiner	23a. Part1. Ent at shock, or hea Immediate Cause (disease or condition resulting in death) Sequentially list conif any, leading to imcause (Disease or that initiated events resulting in death) is	nditions,	b. Due to (c	ich line.	c 0650 quence of):		g, such as cardiac of	•	rest,	Approximate Interval Between Onset and Death
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die	n: To Be	25. Was case referrexaminer? 1 ☐ Yes 2 ☐ 27. Manner of Death	No n	28a. Date o		ER/Outpatien 28b. Time of Injury	t 3 DOA Othe	4 Nursing Ho	me 5 Resid	ne) lence 6 Xother (Spec ow injury occurred	ily) (fospic
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le Funeral	edical Co	29a. Certifier (Check only one)	1 Certifyin 2 Medicel I	g Physician: To the I Examiner: On the ba and mann	sis of examina	owledge, death	occurred at the time restigation, in my of	ne, date and place, a pinion, death occurr	and due to the c ed at the time, d	ause(s) and manner as date and place, and due	stated. to the cause(s)
To th comp	Me	29b. Signature and title of certifier 29c. License number							29d. Date signed (Month, Day, Year) JANUMY 24, 2004 Solfo. Md 21206		
-					7	n 23a) (Type, I					

°Fu Dir	hysicia /Medic Examin Ineral		1. Decedent's Name (First, Middle, Last)			0.0	41.				
°Fu Dir	/Medic Examin		4.1 1 6 1				2. Date of Dea			Time of Death		
°Fu Dir	xamin	aı .	HELPA DOLO	5			01-	Day	Year O4	11:30 PM		
ەFu Dir			4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	Location of Death	4c. County				
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Dir			5. Social Security Number 6. Se	x 7. Age (In yrs.		der 1 Year If Under 24 Hr	s. 8. Date of Birt	h Voor)	9. Birthplac	ce (State or Foreign		
h the Maryland	ector	đ	237 56 SYS/ 10 Usual Residence of Decedent	M 2007	Yrs. Mont	ns Days Hours Mir	DEC. 6	1929	N-CA	mene		
h the Man	/lanc		10a. State 10b. County	10c. Ci	ty, Town or Location				10d	d. Inside City Limits		
h the	is marked other than "natural" or items 23e or 28e-f show eumetic event, the Modical Exprimer must be notified at	ট্	MArylon N/A		BALTIM	THE STATE OF THE S				Yes 2□No		
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d within 72 hours af giene.	ar iii	e	15. Decedent's Edu (Specify only highest grad	e completed)	(Give kind of	sual Occupation work done during most of w Tuse retired)	orking	100. Killa ol Bi	usiness/indu	stry		
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d 2 should be file th and Mental Hy	e e	Be	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle,	Maiden Suman	ne)			
y all	at the	ပ	Frank Murp	14		CORRIL	A MAG	WOST				
sho of bu	E E		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailing Addr	ess (Street and Number or F	iurel Route Numbe	r, City or Town,	State, Zip C	ode) 2/206		
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, - H	item 2 other		20a. Method of Disposition	20b. i	Place of Disposition (Name of	Date	20c. Location -				
g ge c	≃ ່ວ		#⊠Burial 2 □ Cremation 3 □ F	removal from State	cemetery, crematory	or otner place)	1/22/8	Deale	:1/2	Mary loss		
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ite be executed	/Medical systems and systems and systems the purial-transit	ical Examiner	lcai	lcal	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. Endouser	or as a consequence of the conse	Penal Cellitus	Dis	w dis	Cost	
The law requires that the death certifice	attending phy d for use as th	Physician/Mec	L	f			100000					
at the de	detached	ysi	Part II. Other significent conditions con	tributing to death but not res	uiting in the underlyin	g cause given in Part I.				he ceuse of death?		
hat 1	de by	듄					1 🗆 1	es 2□ No	3 Probab	bly 4 Unknown		
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al a	ate has						1 □ Y	es 200 No	1 □ Y	res 200 No		
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Physician:	direc	0	exa <i>m</i> iner? 1 ☐ Yes 2 🐧 No	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 417 Nursing	Home 5□Resid	ence 6 DOth	er (Specify)			
5 8 8	कु⊋	-	27. Manner of Death		28b. Time of	28c. Injury at Work?	28d. Describe h					
g g	fune	힐	1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Yeer)	Injury M	Work? 1 ☐ Yes 2 ☐ No						
or Attending	To the Funeral Director: Atter completely filled in by the funer	Certification:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be determined	-27-20-27-27-27-27-27-27-27-27-27-27-27-27-27-			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Hospital	Funeral	edical Co		sicien: To the best of my kno ner: On the basis of examina								
To the within 2	mple	Mec	29b. Signature and title of certifier	and manner stated.		29c. License nu <i>m</i> ber		9d. Date signed	(Month Do	v Year		
5 × 4	000		. 2	1 la gon	010	T 177		Tale signed	(worth, Da)	22000		
			Moralun H	Uatem,	11/1/	D 15505)	Jan49	1419	5,2009		
J Ul			30. Name and address of person who co	impleted cause of death (liter	m 23a) (Type, Print)	nin stree	1, B-1	6, M1	521	2004		
	Sta	te	31. Date filed (Month Day Year) AN 2 6 2004	32. Registrar's Signa	-			/				

Registrar

HM			State of Maryland / Department of Health and M 1- State Unpend Item #23a&27 per me G828/2/10/04 tas Certificate of Death	lental Hygid Reg	ene 0 0 h	
- 1	Physici	ian	Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Stephen D. Geyek	JANUARY		8:34 P M
	Examir	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	
3			8418 NUNLEY DR PARKVILLE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	BALTIMOR	
o l	Funeral Director		119 - 50-9018 194M 2 F Solver Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign
つ ■	D		Usual Residence of Decedent	-4-1-	20 11/(0)	cy ranks.
	within 72 hours after death with the Maryland ene. Then "netural; or items 23e or 28e-f show the Medical Example of must be notified at	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Ba-f	ecto	MA Baltimore PARKVILLE			1 ☐ Yes 2 🕱 No
	with t	ā	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Cou	ntry?
	ns 23	Funeral Director	2418 Nun ley Dr. Apt B 21234. 11. Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	orify Ves or No-	14. Race - Ameri	can Indian
ယ	or iter	F	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
03	ours a	1 by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		Specify: W	hite.
21215-0036	72 h	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work)	ng 16	6b. Kind of Business/Ir	ndustry
121	within ene. then the Me	dm	Elementary/Secondary (0-12) College (1-4or 5+)		T 05 11 0 0 1	000
	Hygie Hygie sther		17. Father's Name (First, Middle, Last) 18. Mother's Name		Indukai	100.
an	id be ental ked o	To Be	Adam J. Geyer, JR. MART		meisi	=
Maryland	should be and Mental is marked o)	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura			
			Adam J. Gever III. 6 Prospect St. Dec	dham	MA 02	0210.
ore	of He of He fitam r oth		20a. Method of Disposition 1 Derial 2 Cremation 3 Removal from State 20b. Place of Disposition Name of cometeny, compatony of physical place of Disposition (Name of cometeny, compatony of physical place)	ate	c. Location - City or To	own, State
Ĕ	Saltimore, permit. Pages 1 a Department of Hee Importent: If Itam any injury or othe once.		*4 Donation *5 Dother (Specify) EVANS FUNGRAL CHAPT -1-2	5-04. F	OREST 1	HILL, MC
3alt			21. Signature of Funeral Service Licentsee	KVILLE	mD 212	34.
	40 % # 0		Sylverly 4. Sallioliky EVANS FLINERAL CHAH	EL. 0800	HARFORD	RD.
			23a. Part1. Enter the disease. — complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. Ust only one car'se on each line.	r respiratory arres	t,	Approximate Interval Between Onset and Death
7	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Dilated cardiomyopathy			Chisel and Death
	Examiner		Due to (or as a consequence of):			
		ē	Sequentially list conditions, if any, leading to immediate cause. Either Underlying b. Due to (or as a consequence of):			
t	outed d ansit	Examiner	cause (Cisease or injury that initiated events c			
o,	be execute sician and burial-trans		resulting in death) Last Due to (or as a consequence of):			
876	ate br	Ilcal	d			
Box 68760	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial transit	Physician/Med	IF FEMALE:			
Bo	attender for us	lan	23b. Was decedent pregnant in the past 12 months? Solution		23d. Date of delive Month	ery Day Year
P.O.	at the de by the a	nyslo	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown			·
	res that igned b	by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the	ne cause of death?
rds	quire: in sign			1 🗆 Yes	2Æ∏No 3□Prob	ably 4 Unknown
000	aw requir s been si s should	Completed		24a. Was an	24b. Were auto	psy findings available
R	The lav	E		autopsy	d? prior to co	mpletion of cause of
ital	ician: Th certificate ector, pag	Be C	25. Was case referred to medical examiner? 26. Place of Death	(Check only one)	No 1 Yes	2 NO
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Division of Vital Records,	ding Pl h. After tl funera	on:	27. Manner of Death 28a. Date of Injury 1 XNatural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 29c. Injury Work?	8d. Describe how	3 20 2	OCEAN
Sio	tendi Jeath tor: /	catl	2 Accident investigation M 1 Yes 2 No			
i∑	iel or Attendii s after death. el Director: A ed in by the fu	Certification:	determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Bf. Location (Stree City or Town, S	et and Number or Rura State)	I Route Number,
	the Hospitel or Attending hin 24 hours after death. the Funerel Director: After npletely filled in by the fune		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a		-/>-/	
	e Hos 24 h e Fur	edical	(Check only one) (Check one) (Check on	nd due to the caus id at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
	To the Hospitel of within 24 hours at To the Funerel D completely filled in	Me	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month,	Day, Year)
			In of a Green hore ND OCME	J.	ANUARY 24,	2004
			30. Name and address of per in who completed cause of ea. (Item 23a) (Type, Print)			
	.5		Tasha Z Greenberg M.D 111 Penn Street,	Baltimo	re, Maryla	nd 21201
8	Sta		31. Date filed (Month, Day, Year) 32. Begist it's Signature			
	Registr	- 5	JAH 2 7 2004			
DF	HMH 17 Rev 1/20	001	ORIGINAL			
			UNIGHNAL			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Month Dav Dr. Robert Wayne Garrett, DDS 2:45 PM /Medical Jan. 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Towson Greater Baltimore Medical Center Baltimore If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1₩ 2□F Months Days Min. Hours Director 66 Oct. 453-58-0085 21 1937 Texas Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, Its Modical Examiner must be maritimed and any injury or other traumatic event, Its Modical Examiner must be maritimed. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Completed by Funeral Director Lutherville 1 Yes 2 XNo 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1807 Pot Spring Rd. 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No 3 ☐ Widowed 4 ☐ Divorced Specify: Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ Dentist Dentistry 17. Father's Name (First, Middle, Last) To Be 18. Mother's Name (First, Middle, Maiden Sumame) Jack Vernon Garrett Helen Louise Kennon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Joyce J. Garrett/wife 1807 Pot Spring Rd., Lutherville, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Nurial 2 Cremation 3 Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Mays Chapel Cemetery 1/26/04 Timonium, MD 21093 21. Signature of Funeral Samue Lonsee 22. Name and Address of Facility
Lemmon, Funeral Home of Dulaney Valley
10 W. Padonia Rd., Timonium, MD 21093 Lowell M. Lemmon Inc. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** lung Cancel /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No 1 Yes 1 Tes Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Yes 2 No မ Other: 1 Dipatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4305 2004 23 anuny (V) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Todd Baldanza,</u> 10753 Falls Rd., Suite 225, Lutherville, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Gestido Eugenio ANUARY 2004 5:33 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore 8. Date of Birth (Month, Day Ye NOV. 16, If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country)
 Spain 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 1920° **Funeral** Days Hours Min 10X M 2□ F 214-44-1064 83 Director Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits tems 23a or 28a-f show treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Carroll Md. Lineboro Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4601 Rills Rd. 21088 USA death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married neturel', or Baltimore, Maryland 21215-0036 1X Yes 2 □ No Hispanic Specify Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) Colfege (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other treumatic event, ILE MODGS. Diesel Engineer Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Antonio Gestido Peregrina Ribo 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Maria Gestido/ Wife 4601 Rills Rd. Lineboro, Md. 21088 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 XOther (Specify) Entombment Dulaney Valley Mem. 1-24-04 Timonium, Md. ^{22. Name and Address of Facility} Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PERITONITIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PERFORATION OF CECUM Sequentially list conditions, any base of immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed CARCINOMA OF THE COLON that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medicai the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 XNo 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 X No Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No ျှ 3□ DOA 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred Certification: After 5 Pending investigation Intury 1 Natural after death.

I Director: Aff
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in within 24 hours a To the Funeral D 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 01-23-04 1 D 30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS KHOO 7601 OSLER DRIVE TOWSON MARYLAND 21204 M. D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 7 2004 Registrar Cools!

ician	1.	Registrar Decedent's Name (First				Cel	uncal	G UI L	Death		2. Date of Dea Month	Day	Yea	r	me of Death
dical		William C.					45.00	Y	1		Januar				8:05
niner	4a.	Facility Name (If not in Saint Jo	stitution, give s	Medica:	l Cen					OWSC				ltimo	
al or		Social Security Number $219-18-668$ ual Residence of Dece	0 1🖄	M 2□F	Age (In yrs.	last birthday) Yrs.	Months	Days	If Under a	Min.	8. Date of Birt (Month, Day Aug. 22	, 192	9. E 25 Ma	Birthplace (S Country) Brylan	d d
	_		County		10c. Cit	y, Town or Lo	cation							10d. Insi	de City Limi
to		MD Ba	ltimore		Tows	son								1]Yes 2 <mark>X</mark> 1N
To Be Completed by Funeral Director	10	e. Street and Number	Count	An+ 2D			10f. Zig					10g. Citize USA	n of What	Country?	
erai	11	4 Echoway		Apt 2B	nt Ever in U	.S. 13.1			spanic Orio	ain? (Spe	cify Yes or No-		Race - A	merican Indi	an,
Fun		1 Never Married 2		Armed Force 1 XYes 2	s?		If Yes, spe	cify Cuba	n, Mexican	, Puèrto	Rican, etc.)		Black, W	hite, etc.	
dby		3 X Widowed 4 □ D	becrovi	If Yes, Give Year or Date:	s:		1 🗆 Yes	2 KAI NO	Specity:					white	
Completed		15. D (Specify onl	ecedent's Educ ly highest grade	cation completed)		16a. Dece (Give	dent's Usu kind of wo	al Occupa	ation <i>during</i> most)	of worki	ng	16b. Kind	d of Busine	ss/Industry	
duc	•	Elementary/Secondary	(0-12)	College (1-40	or 5+)	Superv		36 / 61// 60/	,			West	ern 1	Electr	ic
BeC		Father's Name (First,							18. Mothe	r's Name	(First, Middle,				
To B		John Ge	rwig						Mabe	1	Kurtz				
ľ	19	a. Informant's Name/R	elationship (Typ	31	ster-	19b. Mailir	ng Addres	s (Street a	and Numbe	r or Rura	l Route Numbe	r, City or	Town, State	a, Zip Code)	
1	20	Elizabeth a. Method of Dispositio		i/in	-law	_ 35 Ac			le A	pt 2	02; Tow			1285 or Town, Sta	ıte.
	20	1 X Burial 2 ☐ Cree	mation 3 🗆 R	emoval from Sta		ney Vall	matory`or (other plac					nium,		110
	2	. 4 □Donation 5 □ 0		100	para				s of Facilit					^k Roa	Д
		▶ Pet	J. U.	Q.							Home			MD 21	
	2	3a. Part1. Enter the disc shock, or heart failu	ease, or compli	cations that caus	sed the deat						The state of the s			Appro	ximate al Between
ı		mediate Cause (Final sease or condition	ro. Elot only on		inoma	of L	una								and Death
ı	re	sulting in death)	C.		as a conseq										-
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nine	ca	any, leading to immedia luse. Enter Underlying luse (Discass or injury	4	Due to (01)	as a conseq	derice or).									
Examiner	th	at initiated events sulting in death) Last	c	Due to (or	as a conseq	uence of):								-	
cai				l											
Med	IF	FEMALE:						-			=				
Physician/Med	23	Bb. Was decedent pregi	nant	3c. If yes, outcor 1☐Live birth	2 Feta	Ideath 3	Ectopic p					23	d. Date of o	delivery Day	Year
ysic		1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregnant 9□Unknowr		eath 5	Other (s	оөспу)	·						
by Ph	Pa	rt II. Other significant	conditions con	tributing to death	n but not res	ulting in the u	nderlying	cause give	en in Part I.		23e. Did to	bacco use	o contribute	to the caus	e of death?
		Pulmonar	y Embol	ism							100	es 2 🗆	No 3□	Probably	4 Unkno
Completed											24a. Was		24b. Were	autopsy find to completion	tings availa
E O											perfor		death	? \	
BeC	25	. Was case referred to examiner?								of Death	(Check only o	/ \			
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lon	27		Pending	28a. Date of I	njury Day Year)	28b. Time o Injury	м	28c. Injury Work	/at <br Yes 2 ∐ !		28d. Describe h	ow injury	occurred		
Certification:		2 Accident 3 Suicide 6 □ 4 Homicide	investigation Could not be determined	28e. Place of building,	Injury - At h etc. (Specia	ome, farm, str			165 2		28f. Location (S City or Tox	treet and n, State)	Number or	Rural Route	Number,
edicai Ce		(Check only 2 1	Certifying Phys Medical Exemin	sician: To the be	s of examina	owiedge, deat ation and/or in	h occurred	at the tim	ne, date an	d place, a	and due to the o	ause(s) a date and p	nd manner	as stated.	use(s)
Med		one) 3b. Signature and title o	f certifier	and manner	stated.		29	c. License	e number			29d. Date	signed (Mo	onth, Day, Ye	ear)
1	-) I I I I I I I I I I I I I I I I I I I	7/	n		10			Z263					-0	
	30). Name and address of	person who co	moleted cause o	of death (Iter	n 23a) (Type	Print)	w .:				01	CI	0.	/
	15.	r. rading ding diguiess of	POLOGII MIIO CO	p.o.ou cause 0	Joan (mai	~oo, (iype,									

			1 - State Registrar	State of Marylar		artment of H		nd Mental Hy	giene Reg. No.		01065
			1. Decedent's Name (First, Middle, Last)	0 -	/			2. Date of D	eath	Year	3. Time of Death
	Physici /Medio	_	CELIA	GOLDM	AN			Month	y 22	2801	8 SOM
7	Examir		4a. Facility Name (If not institution, give st		-	4b. City, Town, o		Death	4c. County		In
			5. Social Security Number 6. Sex	7. Age (In yrs	loat histhstay	If Under 1 Year	If Under 2			Char	ace (State or Foreign
	Funeral Director		212-05-9360	W 000 F	91 Yrs.	Months Days	Hours	Min. 8. Date of B	1912	Count	DE
			Usual Residence of Decedent				<u> </u>	1.00.00	,		
	how		10a. State 10b. County	10c. C	ity, Town or Lo					10	Ad. Inside City Limits
	Ba-f e	Director	MD N/A		BAL	IMORE					1∭XYes 2∐No
	with the	Dire	10e. Street and Number			10f. Zip Code	010	1.5	10g. Citizen of		*
	s 23e	erai	3631 GLENGYLE AVE	NUL #A-6 2. Was Decedent Ever in U	10 12 1	Mac Decedest of h	212		0 14 Ba	ce - America	U.S.A.
	Item Item	Funerai	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 💥 No	J.S. 13.	f Yes, specify Cub	an, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	Bla	ck, White, e	etc.
980	urs al	þ	3 ₩ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		I□Yes 2X No	Specify:		Specif	у:	WHITE
21215-0036	4 within 72 hours after death with the Maryland Jiene rithen "natural", or Itama 23a or 28a-1 ehow The Medical Examiner rust be notilised at	Completed	15. Decedent's Educ			dent's Usual Occup		of working	16b. Kind of B	usiness/Ind	ustry
2	thin a	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)	o. monung		FURNI	TUDE
2	77 (2) 4 44				SALI	ES & DESI		's Name (First, Middl	Maide Curren		TURE
and	a a b y	Be	17. Father's Name (First, Middle, Last) MORRIS		LEIBOW:	T7	LEI	, , ,	s, maideir Sumar		KLASE
Maryland	should band Ment is marked	ဥ	19a. Informant's Name/Relationship (Typ					r or Rural Route Num	per. City or Town.		
<u>S</u>	s 1 and 2 should f Health and Men item 27 is merke other traumatic		MARK GOLDMAN / SO	N	3408	PHILLIPS	DRIV	E - BALTIM	ORE, MD	21208	
ē,	f Heat		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other plan		Date	20c. Location		
E	Peges nent of nnt: If it iry or o		1 X Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			· 1	1/25/2004	BAL	TIMOR	E, MD
Baltimore,	permit. Peg Department Important: I eny injury o		21. Signature of Foneral Service License			. Name and Addre				ROS.,	INC.
<u>m</u>	89 6 8 9		Add 111	with		3900 REIS	TERST	OWN ROAD -	PIKESVI	LLE,	MD 21208
6	Pnysician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.		er the mode of dyir			arrest,		Approximate Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	Due to (or as a conse			,	0.114			
H	Examiner		Sequentially list conditions, b.								
	pe ii	iner	if any, leading to immediate cause. Enter Under vin Cause (Disease or injury	Due to (or as a conse	quence of):						
	recut and I-tran	Examine	that initiated events c. resulting in death) Last	Due to (or as a conse	quence of):						
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687	ficate I physics the L	edical	d.								
Box	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregr					23d. Da	ite of deliver	ry
m	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 1 No	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)	y 		Mo	onth [Day Year
P.0	that the de ed by the a detached	hys	9 Unknown	9□ Unknown							
Ś	es the	by P	Part II. Other significant conditions cont		sulting in the u			23e. Did	tobacco use con		e cause of death?
brd	w requir been si should		THERE CENSI	9,0	(100 nec	470	1 H C.	1	Yes 2 2 No	3 Proba	ably 4 Unknown
ecc	aw Is b	Completed	FIBRILLATION)				24a. Wa	psy	prior to com	sy findings available inpletion of cause of
=		S						per 1 ☐ Yes		death? 1 🗌 Yes 2	2 12 No
Vital Record	Physiclen: The this certificate ral director, page	Be	25. Was case referred to medical examiner?	ospital:		0#	OF.	of Death (Check only			
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	ding P. h. After funer	tion	1 V atural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Wo	rk? Yes 2.⊟N		mon injury coods	100	
Division	Attending er death.	fica	3 Suicide 6 Could not be	28e. Place of Injury - At I	home, farm, str	eet, factory, office			(Street and Numl	ber or Rural	Route Number,
Ö	2 = E	Certification:	4 Homicide	building, etc. (Spec	ufy)			City or To	own, State)		
/	e Hospitel of 24 hours at e Funerel Dietely filled is	edical (29a. Certifier (Check only 2 Medical Examin	ician: To the best of my kr er: On the basis of examin	nowledge, death	occurred at the til	me, date and	d place, and due to the	cause(s) and m	anner as sta	ited.
(류트류승	Medi	one)	and manner stated.							` '
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	10		y		00.17	21	770.		VANU	my	12, 2004
			30. Name and address of person who cou		эт 23a) (Турө,	Print)	WILL	wett 40	SpiTHL	_ Ce	N.Cin
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature			a Comment	region	0	" "
	Regist		JAN 2 7 2004	Sens ra	D die	Desta!					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM #9510e FER FH GOZ7 1/2/104 JH. ____ The profit es Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** SALL HANKS KUTL 200 Y /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Balthack RITCHEY N SEPL HUSPICE /p If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 □ M 2/50 F MARYLAND Yrs. 32 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits *how Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural", or itams 23a or 28a-f shov ury or other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Owings BATHERE Mary or 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 21117 Sara Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: f Yes, Give Year or Dates: 3 Widowed 4 □ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CERMHED NEWSCINE 4 cme JUSIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be FRANCES /IGYYIS LOVJY WILLIAMS 19a. Informant's Name/Relatio ship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Owins MILLS JAKA Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Rost Consey 1-20-04 buson 4 ☐ Donation 5 ☐ Other (Specify) MESSANT mory sus 22. Name and Address of Facility Charles - Uneda Landbox; 21. Signature of Fundal Service Licensee 5200 Reis Trontino Maso 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition renua **Physician** DAG resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit HTN Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? filled in by the funeral director, page 2 should be 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24a Wasan 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No mo disande 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 10 Other (Specify) 1 Yes 2 No Certification: To 3 DOA this 28a. Date of Injury (Month, Day Yeer) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 2 Accident 5 Pending Injury 1 Tyes 2 No 24 hours after death. investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0035712 04

Registrar

State

31. Date filed (Month, Day

Name and address of person who completed days a tribear (firm tibe) (Type,

Dep

32 Registrar's Signature

Everett Haus State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Everett Michael January 24 2004 1249 p^M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 3839 Monteray Road If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Feb. 1, 1926 7. Age (In yrs. last birthday) **Funeral** Birthplece (State or Foreign Country) Months Days Hours 1X M 2□ F 218-22-6815 Yrs. 77 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits in then "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 ☐ No Directo Maryland N/A Baltimore the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 3839 Monteray Road 21218 u.s.A. Funera 12. Was Decedent Ever in U.S.
Armed Forces?

1 DYes 2 No rean
Year or Dates Conflict Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White. à 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Clerical Worker Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental Pages 1 and 2 should be remost of Health and Menta tent: If Item 27 Is marked jury or other traumatic en Michael Haus (Names Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Anita Barrett 5517 Daywalt Ave., Baltimore, MD (niece) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: if eny injury or once. * 4 ☐ Donation 5 ☐ Other (Specity) Gardens of Faith Cem. 1/27/2004 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licens 9705 Belair Rd., Baltimore, MD 28a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Hypertensive Arteriosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical as for use IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Yes 2□No Certification: To 2 ER/Outpatient 3 DOA at scene 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 XNatural 5 🗌 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) January 27 2004 29b. Signature and title of certifier 29c. License number OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2ABINCEAU 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) oouts JAN 2 7 2004

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygien® Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** James Thomas Hood January 23 2004 3:45 РМ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Ellicott City Howard #402 5320 Dorsey Hall Drive 8. Date of Birth (Month, Day, Year Dec 30, 1 If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Mary Land 70 1933 215 30 2450 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County if Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 XNo Director MD Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 5320 Dorsey Hall Drive #402 21042 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1⊠Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 by 1 ☐ Yes 2 🖾 No Il Yes, Give Year or Dates: 1952-54 Specify: Specify. 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Security Guard Security 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Nellie V. Hall James T. Hood Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5 Barnstable Court Owing Mills, MD 21117 James Thomas Hood III/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If its any injury or of once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1-26-2004 * 4 □ Donation 5 □ Other (Specify) Metro Crematory Catonsville, MD permit. 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service License M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5 min Myocardia /Medical Due to (er as a consequence of) Examiner enconor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence Examiner physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medicai use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) the 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Ď 1X(Yes 2 □ No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate ! 1 Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 Nesidence 6 ☐ Other (Specify) Hospital: Certification; To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Aftert 1 Natural 5 Pending after death.

Director: Af
d in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)50835 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar William Dando

2004

27

31. Date liled (Month, Day, Year)

mo

32. Registrar's Signature

Box 68760

P.O.

405 FREDERKKRY SE ZET

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			1 - For State Registrar		nd / Departme	nt of Health and Markete of Death		ne2004	01869
	Physic /Med	ical	1. Decedent's Name (First, Middle, La	emphill		r, Town, or Location of Death	2. Date of Death Month	Day Year 4c. County of Death	3. Time of Death 2:30 M
	Exami Funeral Director		Joseph Rith 5. Social Security Number 6. S	chie		Baltmore, er 1 Year II under 24 Hrs.	8. Date of Birth Month, Day, Yea	NI	place (State or Foreign
	e Maryland 3a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ity, Town or Location Batt	imore			10d. Inside City Limits 1 □ Yes 2 □ No
	15-0036 72 hours after death with the Maryland *naturel; or Items 23s or 28s-f show edical Examiner must be notitied at	Funeral Director	10e. Street and Number SUG N. COUTO 11. Marital Status	11-00 Ave. 12. Was Decedent Ever in L		ip Code 21223 adent of Hispanic Origin? (Specify Cuban, Mexican, Puerto		USA 14. Race - Americ Black, White,	ican Indian,
	d 21215-0036 filed within 72 hours after Hygiene. wither than "naturel", or Ite not, the Medical Examine	þ	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 15. Decedent's E (Specify only highest gra	1 Yes 2 No If Yes, Give Year or Dates: ducation ade completed)	1 ☐ Yes	2000 Specify:	16b	Specify: B	ACK
	Maryland 21215-0036 to 2 should be filed within 72 hours aft than Mental hylpene. 77 is marked other than "naturel; or traumatic event, the Medical Exert.	Be Completed	Flementary/Secondary (0-12) 17. Father's Name (First, Middle, Last	Cellege (1-4or 5+)	House	Cooper	ne (First, Middle, Maide	Dumest	10
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Menial Hygiene. Important: If item 27 is marked other than "raturel; or items 23s or 28s-1 should by injury or other traumatic event, the Medical Examinat must be notified at once.	To	19a Informant's Name/Relationship (rnes(Aunt)	19b. Mailing Address	arrol Hon A	re. Balt	y or Town, State, Zig MOPE I Location - City or To	no 2003
	Baltimore, Mispermit. Pages 1 and 2 Department of Health a Important: If item 27 it eny injury or other tra		Burial 2 Cremation 3 4 Donation 5 Other (Special 21. Signature of Funeral Service Lice	Removal from State (fy)	butus (other place) MeHeny 01-3 and Address of Facility 10	7-04 P	altimore	neral Service
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Carro	mold.	DOUTO NOT	or respiratory arrest,	uts	Approximate Interval Between Onset and Death
36 Am	Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consec					
34 8	68760, ificate be executed g physicien and as the burial-transit	cal	resulting in death) Last	Due to (or as a consec	quence of):		¥ 11-44		
122/1	death cert e attendin	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fett 4 ☐ Pregnant at time of of 9 ☐ Unknown	al death 3 □Ectopic			23d. Date of delive Month	rery Day Year
	Records, P.O. he law requires that the e has been signed by th	by	Part II. Other significant conditions of	ontributing to death but not re-	sulting in the underlying	cause given in Part I.	1 ☐ Yes		bably 4 Dunknown
Hemphi	2 8 8 9	Be Completed	25. Was case referred to medical examiner?			26. Place of Deal	24a. Was an autopsy performed? 1 Yes 2 1	prior to co death?	opsy findings available ompletion of cause of
	Of Phys rethis rail di	L 2	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	OA Cther: 4 Nursing Ho 28c. Injury at Work? 1 Yes 2 No	ome 5 Residence 28d. Describe how in		n HOSPOR
Sylvia	Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	al Certification:	3 Suicide 4 Homicide 6 Could not be determined	building, etc. (Speci	owledge, death occurre	d at the time, date and place,	28f. Location (Street City or Town, Sta	(s) and manner as s	stated.
59	To the Ho within 24 To the Fu completel	Medical	(Check only one) 2 Medical Example one) 29b. Signature and title of certifier	miner: On the basis of examination and manner stated.		on, in my opinion, death occur		Oate signed (Month)	
	(b)		30. Name are address of person who	completed cause of death (be	D 4911	Minderu	MATO	Diffe,	1/22/8
	Regis	ate trar	31. Date filed (Month, Day, Year)	Janes Janes	Ko /				

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 530 PM JANUARY 25 2604 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner BALTIMORE BAYVIEW Flopkins Johns If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1□M 2X F 6/19/1936 Maryland Director 212-34-6897 67 Usuel Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County item 27 is marked other than "netural", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be rediffied all 1 ☐ Yes 2X No Director Maryland | Baltimore Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 958 Middleborough Road 21221 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Telephone Company Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Madeline Fitzpatrick Raymond Owen Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 958 Middleborough Road Essex, Maryland 21221 Gregory Ernest Roth (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1/29 1 XBurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 2004 Gardens of Faith Cem. Baltimore, Maryland 21. Signature of Funeral Service Licensee Bruzdzinski Funeral Hone PA 23a. Part1. Enter the disease, or compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1407 Old Eastern Avenue Essex, Maryland 21221 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEMORR HAGIC SHOCK **Physician** HOURS /Medical Examiner Acrtic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 □ Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 □ Yes 2 ☐ No page 2 should be detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 ☐ Probably 4 X Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate 1 ☐ Yes 2XNo funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ★ npatient 2 □ ER/Outpatient 3 □ DOA Other: 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation the 1 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospital 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of centrier 29c. License number 29d. Date signed (Month, Day, Year) U.D JANKARY RES-000 2004 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN AVENUE MARYLAND JON D. VOCE Johns HOPKINS BAYVIEW HOSPITAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 7 2004 Registrar

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		•	For State Registrar	State of Maryland	I / Department of Health and Certificate of Death		iene
			Decedent's Name (First, Middle, Last,			2. Date of Deat	h 3. Time of Death
	Physicia		FANALIE JEA	11 FER		Month	Day Yeer / 0 2 0 M
-	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of De		4c. County of Death
	LAGIIIII	ŭ.	Sinai Hospite	(Bultimo	16	NA
	Funeral Director	0	5 Social Security Number 6. Set	7. Age (lg.yrs la	st birthday) If Under 1 Year If Under 24 Hours N	in. 8. Date of Birth (Month, Day.	Year) 9. Birthplace (State or Foreign Country)
	p ,		Usual Residence of Decedent	10c City	Town or Location		10d. Inside City Limits
	arylar ahov	_	10a. State 10b. County	Toc. City,	3. IT ansan		1. ☐Yes 2 □ No
	8a-f	octo	1417 10/14		ALIVUITE	1.1	0g. Citizen of What Country?
	with to	ā	10e. Street and Number	LIVERTON A	10f. Zip Code	1	1166
	s 23,	Funeral Director	7000 W: 170	12 Was Decedent Ever in U.S.	13 Was Decedent of Hispanic Origina	(Specify Yes or No-	14. Race - American Indian,
	ltam Lerr	Ë	11. Marital Status 1 ☐ Neyer Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Political	ierto Rican, etc.)	Black, White, etc.
39	irs af	by F	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: BLACK
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Itams 23a or 28a-f ahow fre Mudical Examir et must ke notified at	ted	15. Decedent's Edu	cation	16a. Decedent's Usual Occupation		16b. Kind of Business/Industry
215	hin 7	Completed	(Specify only highest grad Elementapy/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of life. DO NOT use retired)	Working	Hosen In/
2	giene giene	DO.	(1)		ECHNICIAN		1107 11/12
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Itams 23a or 28a-f ahow my injury or other traumatic event, the Modical Extendion matches notified at ance.	To Be (17. Father's Name (First, Middle, Last)	STEL	UART 18. Mother's	Name (First, Middle, M	Maiden Sumame)
ary	should and Men a marke umatic	-	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailing Address (Street and Number of	Rural Route Number	City or Town, State, Zip Code)
	and 2 ealth a m 27 is		HILDA MINGL	ETON _	4104 NEWBURN	QUE, BAL	T.MV, 21215
e,	S 1 a	1 8	20a. Method of Disposition	1 0	ace of Disposition (Name of metery, crematory or other place)	Date	20c. Location - City or Town, State
Ĕ	Pages nent of I int: If ite		1 ☐ Burial 2 Ø Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	temoval from State	151RO	-27-07	A10N9V1/12/1V1
Baltimore,	permit. Departn Imports any inju once.		21. Signature of Soneral Service Licens	land	22. Name and Address of Facility	270 FREDI	41 ION 1959 75 P.A POST MD 21229
1	A see Mining		23a. Part. Enter the gisease, or comp	lications that caused the death	. Do not enter the mode of dying, such as can	diac or respiratory arri	Approximate Interval Between
13	Dhysisian		Immediate Cause (Final	ne cause on each line.	Λ	11. A	Onset and Death
	Physician /Medical		disease of condition resulting in death)	a. Due to (or as a consequ	y vosciles Aco	rgent	
*	Examiner			A low ou	cet seizure	11-201	
	₹ \$ 35	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):		
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	. Hyser	ension		
o,	e exe ian a urial-t	E	resulting in death) Last	Due to (o a a consequ			
8760,	cate be executed physician and the burial-transit	dicai		o Corona	any Artery &	h'seas	2
9	E O S		IF FEMALE:	20. 11			
Вох	e law requires that the death certifi has been signed by the attending je 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
<u>o</u> .	0 0	/sic	1 ☐ Yes 2 ZNo 9 ☐ Unknown	4□Pregnant at time of de 9□ Unknown	eath 5 Other (specify)		
<u>a</u>	hat the	Ph	-	ntributing to death but not resu	Iting in the underlying cause given in Part I.	23e. Did tol	pacco use contribute to the cause of death?
ds,	The law requires that the site has been signed by th bage 2 should be detache	d by	Anomic	of plant	mic Aicoca	1 🗆 Ye	s 2 No 3 Probably 4 Unknown
Record	requestrones	Completed	7,000	2 1 10	+ + 120000	24a. Was a	n 24b. Were autopsy findings available
3ec	has has	E E	regene	J. C.	olul pisedi	autops perform	y prior to completion of cause of death?
a	ilcian: Th certificate rector, pag		OF Management to modinal		00 Plans 4		No 1 Yes 2 No
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 🔏	Othor	Death (Check only on	ence 6 Other (Specify)
	Phys ir this aral dii	5.	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of 28c. Injury at		ow injury occurred
O	ding f th. : After s funer	ţ	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury Work? Mt 1 Tes 2 No		
Division of	or Attending after death. Director: After in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, street, factory, office	28f. Location (SI City or Town	reet and Number or Rural Route Number,
Ó	el or s afte ol Dir	ert	4 D Nothicide	building, etc. (Specify	,	Sity di 10wi	, 5.416)
	To the Hospital or Atlanding Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical (29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	vsician: To the best of my know iner: On the basis of examinat and manner stated.	wledge, death occurred at the time, date and plion and/or investigation, in my opinion, death of	lace, and due to the coccurred at the time, d	ause(s) and manner as stated. ate and place, and due to the cause(s)
	To the within To the comple	₩ Z	29b. Signature and title of certifier		29c. License number	2	9d. Date signed (Month, Day, Year)
	P S P Ö		1/2) A -	~~~	WAS DETUS.		1/22/04
	٥		30. Name and address of person who d	completed cause of death (Item	23a) (Type, Print)	4	1-704
	3		Willie B. MV Ful		mnonite He AV	catanal	11e un 21228
¥.	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signat			
	Regist	rar	IAN 9 7 2004	29	and the same of th		

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G			1 - State Amend & Unpen	d State of Maryland	/ Depart Certif	ment of Hi icate of L	ealth and Death		39842		01872
			1. Decedent's Name (First, Middle, Last					2. Date of De.	ath	NOTE:	3. Time of Death
	Physici /Medio		John U Jac	KSON JR.				Janua	Day	2004	11:52 A ^M
7	Examir		4a. Fecility Name (If not institution, give	street and number)	4	. City, Town, or	Location of Dea	th	4c. Coun	ty of Death	
			2703 East Chase			altimor				NA	
200	Funeral Director		5. Social Security Number 6. Se 19 19 19 19 19 19 19 19 19 19 19 19 19	x 7. Age (In yrs. las		Under 1 Year onths Days	If Under 24 Hr Hours Mir		Year)	9/ Birthpl Coun	ace (State or Foreign try)
	/land		10a. State 10b. County	10c. City, 1	Town or Locati	on				11	Od. Inside City Limits
	ith the Marylar or 28a-f show	ţċ	MD N/A		PaH	imore	,				1 yes 2 No
	th the	lrec	10e. Street and Number	\ <u></u>		Of. Zip Code			10g. Citizen of	What Coun	try?
	23a	la	1024 Bristol +	lace		2	1225		U	3A	
	after dea or Items	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Apped Forces?	13. Was	Decedent of His s, specify Cubar	spanic Origin? (n, Mexican, Pue	Specify Yes or No- nto Rican, etc.)	14. Ra	ce - America	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Menial Hygiene. item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic svant, the Mydical Examiner must be rediffed at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Yes 2 □ No If Yes, Give Year or Dates:	4 10	Yes 2 No	Specify:		Speci		onk
9-0	72 hours "natural",	ted	15. Decedent's Edu (Specify only highest grad	ication 1	16a. Decedent	s Usual Occupa	tion		16b. Kind of E	Business/Ind	ustry
21	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO	VOT use retired)	uring most of we	orking	TEMP	DIS	ribution
21	filed wi Hygien other th	Co	12th GRADE	IYR.	IRU	CK D	river		of M	10	INC.
Pu	be fit ntal H od ott	Be	17. Father's Name (First, Middle, Last)	90			18. Mother's Na	me (First, Middle,	Maiden Suma	me)	
Maryland	should I nd Men marke	ဥ	John C Jackson	10K.			Orlir	ley Kr	light		
<u>a</u>	12 st thand 7 Is n traun		19a, Informant's Name/Relationship (T)	VSIM (mulha)	19b. Mailing A	ddress (Street a	nd Number or F	ural Floute Numbe	r, City or Town	, State, Zip	Code)
	1 and Health em 27 ther tr		20a. Method of Disposition	20b, Plac	e of Disposition	n (Name of	ILU R	Date AI	20c. Location	VH	20021
JO.	ages int of t: If it		1 Burial 2 □ Cremation 3 □ F	Removal from State	etery, cremato	ry or other place) - 6 01	2101	10/000	-14	1/A
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic avant, the Meone.		* 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	, ilid C	Y JOHN K	Me and Address	COLOI-	24-04	VVHKTI	ea	VH
Ba	permit. Departimport. sny inj			time	551	Bo Ho	MALID	r Dal	Limon	D TANC	era Senica
Sec.			23a. Part1. Enter the disease, or compishock, or heart failure. List only o	ications that caused the death.	Do not enter th	e mode of dying	, such as cardia	c or respiratory ar	rest,	-)-1114	Approximate
No.	Physician	4	Immediate Cause (Final disease or condition	NARCOTIC I	CAPPONT TO	AGTOM AGTOM					Interval Between Onset and Death
7	/Medical		resulting in death)	Due to (or as a consequen		MITOM					
	Examiner		Sequentially list conditions,	0.							
	D ii	iner	if any, leading to immediate name. Frite Underlying Cause (Disease or injury	Due to (or as a consequen	nce of):						
	and I-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a consequen	oce of):						
8760,	cate be executed physicien and the burial-transit	alE			100 01).						
687	ficate physis the	edical		J							
Вох	eath certif attending for use a	Ž	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregnancy					23d Da	ate of deliver	v.
	death e atte d for	Icla	in the past 12 months?	1 Live birth 2 Fetal de 4 Pregnant at time of death		opic pregnancy er (specify)					Day Year
P.0	The law requires that the death certifi tie has been signed by the attending bage 2 should be detached for use as	by Physician/M	9 □ Unknown	9☐ Unknown							
	es tha gned be de	by P	Part II. Other significant conditions con	ntributing to death but not resulting	ng in the under	ying cause giver	n in Part I.	23e. Did to	bacco use con	tribute to the	cause of death?
ord	v requir been si should		HYPERTENSIVE CARD	IOVASCULAR DISE	EASE			1 🗆 Y	es 2 🗆 No	3 Proba	bly 4 DUnknown
ecc	law r as be	ompleted						24a. Was a	n 24b.	Were autop	sy findings available pletion of cause of
= E		Co						perfor	med?	death?	l□ No
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		-			ath (Check only or			
Division of Vital Records,	Phys this al dii	2	1, Yes 2 No 27. Manner of Death			□ DOA Other	+ Nulsing a	dome 5 ☐ Resid			At scene
n	5 9 9	lon	1 □Natural 5 □ Pending	Foundth, Day Year)	b. Time of Found a	28c. Injury	at Pes 210 No	28d. Describe h		red	
S	Attending ir death. actor: After by the fune	flca	3 Suicide 6 Could not be	1/18/04 7:	:30 a		23 23110	Unknow		han or Dural	Parita Numbas
D	after Dira	Certification:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)		actory, ornes		City or Town Baltimor			Chase St.
	Nospitel or Attendin n 24 hours after death. No Funeral Diractor: Af pletely filled in by the fur	alc	29a. Certifier 1 Certifying Phy	Found In Dwell sician: To the best of my knowle	dge, death occ	urred at the time	, date and place	and due to the c	ause(s) and m	annor ac eta	ted.
	To the Hosponith 24 hosponith 2	edical	(Check only and cal Exemi	ner: On the basis of examination and manner stated.	and/or investi	gation, in my opi	nion, death occi	urred at the time, d	ate and place,	and due to t	he cause(s)
	withi To 1	Σ	29b. Signature and title of certifier	~		29c. License			9d. Date signe		
			I my hi.	mid		O.C.M	.E.		anuary	19, 2	004
			30. Name and address of person who co							_	0.46
	- 01	,,,,		32. Registrar's Signature		11 Penn	Street	, Baltimo	re, Ma	ryland	21201
	Sta		31. Date filed (Month Day, Year) JAN 2 6 2004	Deve Signature	An	Co Ha					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month 35 PM **Physician** DOSEPH /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth Fecility Name (If not institution, give street and number) Examiner MMedicalC BALLIMORE HIMDRE N/A If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Sept. 14, If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In yrs. lest birthday) 5. Social Security Number 6. Sex Year) Maryland **Funeral** Days Months 1 X M 2 □ F 1926 214-22-9729 77 Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County 1 ☐ Yes 2 X No Timonium Baltimore Director Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number USA 21093 309 Presway Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Maritel Status 1 Never Merried 2 Married 1 ☐ Yes 2 ☐No Specify. White Baltimore, Maryland 21215-0020 Specify: Š 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementery/Secondary (0-12) HVAC Mechanical Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Lest) Be Helen Huber Joseph F. Kirkwood 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 309 Presway Rd. Timonium, Md. 21093 Mrs. Louise Kirkwood/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Co. 1-26-04 Towson, Md. 21. Signature of Fune al Service License. Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Physician/Medical Examiner or Attanding Physician: The law requires that tha death certificate be executed use as the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events Due to (or as a consequence of): and Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be detached 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 1 ☐ Yes 2 ☐ Ho 2 No 1 Yes certificata funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical Hospital: Inpatient examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA edical Certification: To 1 Yes 2 No After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury et Work? 1 Naturel 2 Accident 5 Pending investigation 1 Yes 2 No s after death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined within 24 hours after dea To the Funeral Diractor complataly filled in by th 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture and title of certifie 15106 who completed cause of death (Item 23e) (Type, Print) 30. Name end address of person St BALTOMD 21201 12+1 HO GREENE 10 LON 31. Date filed (Month, Day, Year, 32. Refistrer's Signature State JAN 2 2004 Registrar

			For State Registrar	State of Ma	ıryland		artmeni tificate			ınd M		giene Reg. No.	I me feet to	Total .	01071
١	Physicia	an	1. Decedent's Name (First, Middle, Las	it)			3 7 73	CA: 1	11		2. Date of De. Month	Day		ar,	3. Time of Death
,	/Medic	al	1 A Y	B4			Ah Cibi	744	Location of	f Dooth	JANJAG	+	County of t		11:53/4M
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u _s	Funeral		Social Security Number 6. S	ex 7. Age	1.0	ast birthday)	If Under	1 Year	If Under 2	24 Hrs.	8 Date of Bir	th Your	,		
	Director		212-45-8022	□M 2 7 F	84	Yrs.	Months	Days	Hours	Min.	MAY 19	,191	9	Coun	lace (State or Foreign try) UKRAINE
	pu &		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							11	0d. Inside City Limits
	Aaryla Febor	5		IMORE			ΓΙΜΟRI	F							1 ☐ Yes 2 ☑ No
	28a-	Director	10e. Street and Number	THORE		DAL	10f. Zip					10g. Citi	zen of Wha	it Coun	try?
	h with	a D	6946 MILBROOK PA	ARK DRIVE	#2B				212	15					UKRAINE
	ems a	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S	S. 13. \	Vas Deced	ent of His	spanic Orig	jin? (Spe , Puerto f	cify Yes or No Rican, etc.))-	14. Race Black, \		
	n 72 hours after death with the Marylan "natural", or flems 23a or 28a-f show valical Examinar most be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 N If Yes, Give Year or Dates:	lo		1□Yes 2		Specify:				Specify:		WHITE
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y	hould d Mer marke marke	은	GERSH 19a. Informant's Name/Relationship (1)	Type Printl				(Street a			i Route Numbe			te Zin	Codel
2	and 2 s eaith an n 27 is u		VLADIMIR KOSOY /	SON			-				#3B - E				
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	Pages nent of I ant: If it		1 🕅 Bunal 2 ☐ Cremation 3 ☐ • 4 ☐ Donation 5 ☐ Other (Specify				-			AR 1	/23/200	04	ROSI	EDAL	E, MD
Dall	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Ite MODE.		21. Signature of Funeral Service Licen	Cutt	Qu.		. Name and				L LEVII ROAD -				, INC. MD 21208
T	Br a s		23a. Part1. Enter the disease, or companies shock, or heart failure. List only	plications that caused one cause on each lin	the death	n. Do not ent	er the mode	e of dying	, such as o	cardiac o	r respiratory ai	rrest,			Approximate Interval Between
H	Physician		Immediate Cause (Final disease or condition	a ATH 6200	OLLE	ROTIL	CAR	-012/	13cui	12	PISERS	E			Onset and Death
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'n	es tha bengi	by P	Part II. Dther significent conditions of	ontributing to death bu	it not resu	ulting in the u	nderlying ca	ause give	n in Part I.						e cause of death?
Solos,	een s	ted									10,	Yes 2[] Proba	
שר	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed				· · · · · ·					24a. Was autop perfo	osy ormed2∕	24b. Wer prior deat	e autop r to con th?	psy findings available inpletion of cause of
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õ =	ng Ph Iter th neral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	y Yeer)	28b. Time of	2	8c. Injury Work	at ?	2	8d. Describe	how injur	y occurred		
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2	or At after of Direct in by	Certification;	4 Homicide determined	28e. Place of Inju- building, etc	iry - At ho :. (Specify	me, farm, str /)	eet, factory	, office		2	City or Tox			r Hurai	l Route Number,
	spital		29a. Certifier 12 Certifying Ph	ysicien: To the best of	of my know	wledge, deatl	occurred	at the tim	e, date and	d place, a	and due to the	cause(s)	and manne	er as st	ated.
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	(Check only 2 Medical Exen	niner: On the basis of and manner sta		tion and/or in	estigation,	, in my op	inion, deat	h occurre	ed at the time.	date and	place, and	due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	Dalil	*			License					e signed (M		
•			Milchael	Nothik	41		D	4341	91			JHIVL	TOLY :	10,	2004
	/		30. Name and address of person who	completed cause of de	eath (Item	23a) (Type, ひとんて R	Print)	RAT	TALL	STUN	IN NI	124 L	AND	21	133
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signa	turo			-						-
	Registr	rar	JAN 2 7 2004	Dense	1	9 1	oork.	21							

State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** JANUARY beR alter 2004 3:41 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Fown, or Location of Death 4c. County of Deeth Examiner Saint Joseph Medical Center Towson Baltimore 7. Age (In yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, last birthday) 5. Social Security Number 6. Sex Birthplace (Stete or Foreign Country) **Funeral** 100 M 2□ F 2 214-12-3921 0 Director Mari Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Heatilb and Mental Hygiene.
Item 27 is marked other than "netural", or itema 23e or 28a-f ahow ither freumatic event, the Musical Examinar markle incititied at 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 Ves 2 No Director MORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Ave 21206 Funerai 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Anned Forces? 1 IX Yes 2 ☐ No IVYes, Give Black, White, etc. 1 Never Married 2 Married 1□ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: Completed by White 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DERVISOR osta 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be enewoper tera mano ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ashburn : if item 27 is or other tre arole 20b. Place of Disposition (Name of cemetery, crematory or other place) VH Quare 20147 20c. Location - City or Town, State Date 20a. Method of Disposition Pages Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. talkwood Cemekry -31-04 rackville. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address Facility BALTMORE, MD 21. Signature of Funeral Service Licensee 21234 Intelle CHAPEL 8800 HARFORDRD 101 EVANS FUNGRAL 23a. Part1. Enter the disperse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIO-RESPIRATORY ARREST HOURS /Medical Due to (or as a consequence of). Examiner ARRYTHMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed CORONARY ARTERY DISEASE and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the 9☐ Unknown 9 Unknown ģ been signed to should be deti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PULMONARY HYPERTENSION 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed LACTIC ACIDOSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy rmed? 2 X No RENAL INSUFFICIENCY 2 No 1 ☐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Ninpatient 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Yeer) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 701 W -Z5 NCUM D31826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrars Signature OSLER DRIVE, TOWSON, MARYLAND 21204 7601 31. Date filed (Month, Day, Year) State 2 Registrar

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		1	State Registrar				ertifica				Reg. N	San Ser G	2	4-1 5 1 6
		-	1. Decedent's Name (First, Middle							2. Date of D		ay Y	'ear	3. Time of Death
	Physiciar /Medica	_	LINDA SUE	LANGFOR	.D					JAN.		2004		0345 A ^M
	Examine	•	4a. Fecility Name (If not institution	_			4b. Cit	y, Town, o	r Location of Deat	h		c. County of		
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	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 💢 F		yrs. last birtho	Month	er 1 Year S Days	If Under 24 Hrs. Hours Min.	(Month, D				lace (State or Foreign try)
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	land Now		10a. State 10b. County		100	c. City, Town o	r Location						1	0d. Inside City Limits
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	23a c	2	606 UMBRA S	TREET				2122	24			USA		
	ems ermi	Lanera	11. Marital Status	12. Was De Armed	ecedent Ever Forces?	in U.S.	3. Was Dec	edent of H	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No Rican, etc.)	lo-	14. Race - Black,	Americ White,	
36	ars afte		1 Never Married 2 Marr	If Yes,					Specify:			Specify:		
Ö	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, I'm Medical Evarries must be notified at	2 -	3 ☐ Widowed 4 ☐ Divorced	Year or	Dates:	16a De	cedent's Us	ual Occur	nation		16b 3	Kind of Busi	WHI	
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lar		0	JAMES JEWE	LL					JEAN	WOODW	ARD			
Baltimore, Maryland 21215-0036	2 6 6 5		19a. Informant's Name/Relations		DAND		-		and Number or Ru					
2	1 and 2 Health lem 27 l	Ŋ.	JACK LANGFOR	U / HUS					TREE CT	-	-			322
ore	m O		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation	3 □Removal fro	m State		crematory of	other plac		Date		ocation - Ci		
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Bai	permit. Page Department. Important: If any injury o		21. Signature of Funeral Service	Lidensee	70 /	2			ŠKI FUN IDALK AV					21222
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications tha	t caused the	death. Do not	enter the m	ode of dyin	ng, such as cardia	or respiratory	arrest,	IUILL ,	111	Approximate Interval Between
	Trysician	4	Immediate Cause (Final disease or condition											Onset and Death
	/Medical	-1	resulting in death)	Due !	o (or as a co	nsequence of):	310		1.1.00	,,,,,,	-			
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Box (attending physician at for use as the buriat-	FIIysiciani/medical	IF FEMALE: 23b. Was decedent pregnant		outcome of pr							23d. Date	of delive	IV
B	d for	200	in the past 12 months?	4□Pre	e birth 2 🗌 gnant at time		3 ☐Ectopic 5 ☐ Other (Month		Day Year
P.0	that the de ted by the detached	2	9 Unknown	9□Un	known									
ω̂.	es tha igned be det	Dy L	Part II. Other significant condition	ons contributing to	death but no	t resulting in th	e underlying	cause giv	en in Part I.	23e. Did	tobacco	use contrib	ute to th	e cause of death?
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of V	S S S S	2	1 XYes 2 □ No			2 ER/Outpa		-	4 Li Nursing F	lome 5 Re)
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	at a start	73	2 ☐ Accident investig	yation			М	1 4	Yes 2 □ No					

signed by the attending physician and d be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should t

Medical Certification

3 🗍 Suicide

4 Homicide

(Check only one)

State Registrar 29b. Signature and title of certifier

6 Could not be determined

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number O.C.M.E

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) JAN. 24, 2004

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

G. Reference 111 1
ar) 32. Registrar's Signature
1972014 Separate JAN 2 7 2004

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

		•	For State Registrar	State of Maryland	d / Department of Ho		tal Hygiene	/ 11111	. 0107
s d	Physici /Medio		1. Decedent's Name (First, Middle, Last)	e Lack	ner	2. [Date of Death Month Da	18 200 4	3. Time of Death
	Examir Funeral Director		5. Social Security Number 6. Sex 21 2-1 2-4829	Treet and number) 7. Age (in yrs. ia		ONIOM If Under 24 Hrs. 8. [Hours Min.	Date of Birth Month, Day, Year,		MORC place (State or Foreign cyland
	within 72 hours after death with the Maryland ene. than "naturel; or items 23s or 28s-1 show than "naturel Examiner must be notified at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County Md. Baltim 10e. Street and Number 824 Loyola Drive	ore	Town or Location Towson 10f, Zip Code	21204	10g. Ci	tizen of What Cou	10d. Inside City Limits 1 □ Yes 2 XNo ntry?
215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryla nt of Health and Mental Hygiene. If item 27 is marked other than "naturel", or items 23a or 28a-1 show or other treumatic event, ite M. of ral Explainer or unit be notified at	ρ		2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of His If Yes, specify Cubar 1 Yes 2 No	spanic Origin? (Specify n, Mexican, Puerto Rica Specify:		14. Race - Americ Black, White, Specify:	etc. Unite
7	filed within 72 Hygiene. other than "na ent, Ille Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	completed) College (1-4or 5+) 5+	(Give kind of work done done done done done done done done	uring most of working	E	ducation	
Maryland	2 should be filed within and Mental Hygiene. Is marked other than eumatic svsnt, Ille Ma	To Be	Alexander B. 19a. Informant's Name/Relationship (Ty)		19b. Mailing Address (Street a	Katheri	ne L. Mo:	rton	o Code)
_	permit. Pages 1 and 2 Department of Health important: If Item 27 i eny injury or other tre pnce.		Mr. Thomas G. Lache 20a. Method of Disposition 1 \(\text{Description} \) 1 \(\text{Description} \)	emoval from State 20b. Pla	4479 Silver Pes ace of Disposition (Name of Immetery, crematory or other place	Date (20c. L	Georgia 3 ocation - City or To	own, State
Baltimore	permit. Pag Department Important: I any injury o		*4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	/ Rust	1050 York	^{s of Facility} Ruck : Road Tows	Towson Fi son, Mary	uneral Ho	
0,	Physician /Medical Examiner physician physician the prival-transit physician	Examiner	23a. Part1. Enter the disease, or conformation shock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):	, such as cardiac or res	piratory arrest,		Approximate Interval Between Onset and Death
.O. Box 68760	The law requires that the death certificate be ate has been signed by the attending physicic page 2 should be detached for use as the bu	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 Ectopic pregnancy		- 7	23d. Date of delive	ery Day Year
Records, P.	w requires that been signed b should be deta	leted by PI	Part II. Other significant conditions con	tributing to death but not resu	Iting in the underlying cause give	\	23e. Did tobacco	⊠No 3 Prot	he cause of death? pably 4 Unknown posy findings available
Vital Re		Be Comp	25. Was case referred to medical examiner?			26. Place of Death (Ch	autopsy performed? 1 ☐ Yes 2 ☑ No	prior to co death?	mpletion of cause of 2⊠ No
of	Attanding Physician: r death. sctor: After this certific by the funeral director.	ဥ	1 Yes 2 No 27. Manner of Death 12 Natural 5 Pending 2 Accident investigation		ER/Outpatient 3 DOA Othe 28b. Time of Injury Work M 1 Y	402 Norsing Home	5 Residence Describe how inju		(y)
Division	in Dirig	i Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	building, etc. (Specify,			City or Town, State		
F	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical		ner: On the basis of examination and manner stated.	wledge, death occurred at the timion and/or investigation, in my op	inion, death occurred at	the time, date an	and manner as sid place, and due to	o the cause(s)
)_	10		30. Name and address of person who co	, M.D. 2300 D	DULANEY VALLEY	ROAD TIMON	IUM, MD	21093	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure				

DHMH 17 Rev 1/2001

Registrar

9:25 P.M.

KATHARINE LACHER JANUARY 18, 2004

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 7:45 PM 23, Dorothy Barnett Larrimore January 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Millennium Marley Neck Glen Burnie Arundel Anne If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) JUN 1, 1920 Birthplace (Stete or Foreign Country) 6. Sex **Funeral** 1 □ M 2 🖾 F 212-16-0886 83 Marvland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28e-f ahow any injury or other traumatic event, the Medical Exeminary. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Glen Burnie Marvland Anne Arundel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 205 Vernon Avenue 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No ğ Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Alonza Barnett 2 Mary Cole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James R. Larrimore, Sr./Husband 205 Vernon Avenue Glen MD 21061 Burnie. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ° 4 □Donation Baltimore, MD Metro Crematory, Inc. 01/24/04 21. Signature of Funeral Service Licensee

Edward A. Gregorchik

23. Name and Address of Facility
Cremation Society of MD
299 Frederick Road Balt

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cremation Society of MD, Inc 299 Frederick Road Baltimore MD 21228 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) enopolenotion Physician /Medical Examiner hon 1000 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last the attending physician and (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 2 | Fetal death ŏ in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has certificate Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 4 Nursing Home 5 ☐ Residence 6 ☐Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient Certification: To 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide pelli Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ihe. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 50568 January 24, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V Shobha Reddy, 7845 Oakwood Road, Ste. 204, Glen Burnie, MD 21061 M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** CALVIN LAWSON LAINR GUCE lanuary 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimase City If Under 24 Hrs. 8. Date of Birth Month, Day 7. Age (Inlyrs. last birthday) renera libruland If Under 1 Year 6. Şex 1 M 2 □ F Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits th end Mental Hygiene. 7 is marked other then "netural", or items 23a or 28e-f show traumatic event, the Medical Examinar must be notified at 14 Yes 2□No BAIHMOTE Director MARRINANO if £05 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2/2/7 USP 5 tre Et 4ECHEN Funerai 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1,8 Yes 2 ☐ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced Black Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Officer 24 CARS 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be LAWSONN, Jr ဥ HARVEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's ame/Relationship (Type, Print) W. CHARICS ST ASI Depertment of Health er Important: If Item 27 is any Injury or other trau BALTANOE MARYLAND LAWSON H1/8.5/EK 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility C 21. Signature of Funeral Service Licensee Med d Bollsmire Krey 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or height failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner To Be Completed by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Tes 2 1 No 1 ☐ Yes 2 ☐ No director, 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | 1 | 1 | 1 | 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medicai Certification: 28b. Time of 1 Natural 5 Pending investigation 1 Yes 2 No death. Director: And in by the fo 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours e To the Funerel C completely filled pelli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WAZIR SHAHID MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 6 2004 Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 01220 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 00 PM 2004 IAN /Medical 4a. Facility Name (If not institution, give street and 4b, City, Town, or Location of Death 4c. County of Death Examiner Rtord IRCLE 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days 1□M 21 F Hours 214-30-1845 Usual Residence of Decedent 1845 Director 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show the Medical Examiner must be nutitied at 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? itams 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 IINo If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 ☑ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the termonages. (Give kind of work done during most of working life. DO NOT use retired) College (1/4or 5+) Elementary/Secondary (0-12) 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) cholas 10011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 1/4 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) Date 20c. Location - City or Town, State Bel Air MO Beldic Mem. Gardens 21. Signature/of Funeral Service Licensee 22. Name and Address of Facility 3 NEWFORT DR. FOREST HILLIM GIANS FUNGRAL CHAPTURBELAIR 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Vist only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ADEND CARCINOMA OF PANCREAS MONTHS MEIRSTATIC /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lieute Service) that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): the attending physician hed for use as the burial P.O. Box 68760. Physiclan/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12/months?

1 Yes 2 No 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Day Year 5 Other (specify) be detached 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by IPERTENSIDN 1 ☐ Yes 2 🗆 No 3 Probably 4 ∰Unknown peen (24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 **N**O Other: Medical Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) this in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation death. 2 🗌 No 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled within 24 hours a To the Funeral I 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certified 29c. License numbe 29d. Date signed (Month, Day, Year) 0 250 angri 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1D ABHYANKAR 2 MD Μ. XVE

Registrar

State

31. Date filed (Month, Day, Year)

2

7

and a

32. Registrar's Signature

RKD 04-00539 GORDON L.MILLER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 19,2004 1:45P. JANUARY ORDON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE **ESSEX** 1700 OLD EASTERN AVE Il Under 1 Year Il Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Securify Number 6. Sex **Funeral** Days Hours Months 1XM 20 F MAR 217-50-156 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a. State items 23a or 28a-f show the Madical Examinar must be notified at 1 ☐ Yes 2 No MARYLAND Director ALTIMORE SSEX 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21221 ASTERNAVENUE, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 D No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married ò 1□ Yes 2⊠ No Maryland 21215-0036 VHITE Specify: Specify: δ 3 Widowed 4 Divorced 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event. If Item OSEDALE ARNIVAL ABORER 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Be AMES LIAM ္ပ BROTH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, cremators JERALD WILLIAM Baltimore, Date 20c. Location - City or Town, State 20a. Method of Disposition cometery, crematory or other place)
EVANS FUNDS ALCHAR
BEL AIR 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 ☑ Other (Specify) 21. Signature of Fineral Service Licenses 22. Name and Address of Facility YORK ROAD. Approximate Interval Between Onset and Death 23a Part 1. Enter the disease, or complications that caused the death, shock, or heart lailure. List only one cause on each ling. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, the attending physicien by Physiclan/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death use 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year signed by the atte in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Ö 9 Unknown 9 Unknown مَ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

12 Yes 2 \[\times \] No has page 2 Yes 2 🗀 No Division of Vital the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check Be Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) SCENE Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA ပို 1X Yes 2 □ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred After t Certification: or Attending 1 Natural 5 Pending investigation 2 □ No 1 TYes death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatuji JANUARY 20,2004 O.C.M.E. address of person who completed cause of death (Item 23a) (Type, Print) Aten 111 Penn Street, Baltimore, Maryland 21201 31. Date liled (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene A A I. For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Yeer Month **Physician** MARTIN MARY JANUARY 22 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE RANDALLSTOWN CENTER HOSPITAL NORTHWEST If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 78 Ontario Can Director 386-12-6709 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location itam 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avant, the Maulical Examinar must be notified at 1 ☐ Yes - R ☐ No Director Md. Baltimore Reisterstown 10f. Zip Code 21136 10g. Citizen of What Country? 10e. Street and Number USA 220 Park Holme Circle Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 □ Yes 2□ No Baltimore, Maryland 21215-0036 White Specify 3 ☐ Widowed ¥ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired).
HOUSEWITE 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Menial Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic avant, the Meule occe. Elementary/Secondary (0-12) Cotlege (1-4or 5+) Own Home 12 Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Burton LaRoy Eva Gladys Evans P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Garland H Martin - Son 5 Wyndfield Dr. Hanover, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 1/31/04 Evergreen Mem. Finksburg, Md. 11824 Reisterstown Rd. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home Reisterstown Md. 21136 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part1. Enter the disease, or com shock, or heart failure. List only Approximate Intervat Between Onset and Death Immediate Cause (Final FAILURE ESPIRATORY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown 2 Fetal death 3 □Ectopic pregnancy 1 Live birth ŏ Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) page 2 should be detached 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 XUnknown 1 ☐ Yes 2 ☐ No been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed? Yes 2 No has certificate 1 ☐ Yes or Attending Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 1 🗆 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Impatient 2 ER/Outpatient Certification: To 3□ DOA this 28c. tnjury at Work? 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred 27. Magner of Death After Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation the f within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated. Medical 29a. Certifie completely 29d. Date signed (Month, Day, Year) 29b. Signature artistitle of certifier HYSICIAN JA ND TANUARY D42723 of person who completed cause of death (Item 23a) (Type, Print) NORTH WEST CENTER. HOSPITAL 30. Name and addres HARISH. AVVERAHALLI CLP COURT ROAD 5401 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 27 2004 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 7:38a.m. William Francis Munchel on of Death 4c. County of Death /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5. Social Security Number 6. Sex Baltimore Hospital If Under 1 Year 8. Date of Birth (Month, Day, Year) July 28, 1929 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1₩ 2□ F Months Days Hours 220 22 1298 Yrs. 74 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is merked other than "natural", or items 23a or 28a-f sho traumetic event, the Modical Examinar must be notified at 1 □ Yes 2 □ No Funeral Directo Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1207 Shore Road 21220 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mentel Hygiene. marked other than Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) 12 Fire Department Fireman 17. Fether's Name (First, Middle, Last, permit. Pages 1 and 2 should be file Depertment of Health and Mentel Hy Important: If item 27 is marked oth any injury or other traumetic event 18. Mother's Name (First, Middle, Maiden Surname) Leo Munchel Catherine Weinman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Juanita Munchel (wife) 1207 Shore Road Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Gardens of Faith Cem. 01/26/2004 Baltimore County, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home PA 21. Signature of Funeral Service Licenses 1407 Old Eastern Avenue Essex MAryland 21221 Part Enter the disease, or complications that used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical rocardial **Examiner** Examiner To the Hospital or Attending Physician: The law requiras that tha death certificeta be executed ed by the ettending physician end detached for use es the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2□ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Jas certificata 20 No 1 🗆 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 Other: 1 Yes 2 No 1 10 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) eral Director: After this filled in by tha funeral di 28c. Injury et Work? Certification: 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 2 No death. 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral C completely filled edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) 22/04 0057721 16 MI

Registrar

State

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Munchel,

JAN 27 DHMH 16 Rev 6/95

32. Registrar's Signature

30. Name and press of person who completed cause of death (Item 23e) (Type, Print)

Oteele

aura 31. Date filed (Month, Day, Year)

Baltimore MD. 21237

			For State	State of Ma	arylan			e Ink. nt of F <i>te of</i> .				giene		01881
			Registrar 1. Decedent's Name (First, Middle	(act)			unca	ie or i	Deali	,	2. Date of De	Reg. No.		3. Time of Death
	Physicia /Medic		Ernest Ott	to Malin							Januar	Day	5, 2004	
	Examin		4a. Facility Name (If not institution, Stella Maris H					, Town, o Lmoni		n of Death			County of De Baltimo	
7,0	Funeral Director		5. Sociel Security Number 215-10-4349	6. Sex 7. Ag 1 XM 2 ☐ F	e (In yrs. i	ast birthday) 7 Yrs.		Days	If Unde Hours	er 24 Hrs. Min.	8. Date of Bird (Month, Da DEC 20	h y, Year) 1	916 Ma	inthpface (State or Foreig Country) aryland
	3 3		Usual Residence of Decedent 10a. State 10b. County		10c. Cib	, Town or Lo	cation							10d, fnside City Limits
	f sho	to	Maryland Balti	imore		kvill								1 ☐ Yes 2X No
1	3a or 28a	I Direc	10e. Street and Number 8401 Avondale	Road	1			ip Code 21234				10g. Citi USA	zen of What C	Country?
	perint. Tages I and a stoom be interwining to nous are used war in the maryana Department of Health and Mental Hygiene. Insportant: if I tem 27 is marked other than "natural", or Itams 23s or 28s-f show any injury or other traumatic event, if a Medical Examinar must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 ff Yes, Give Year or Dates:		1	Was Dece if Yes, spi	ecify Cuba	lispanic C an, Mexic Specif	an, Puerto	ecify Yes or No Rican, etc.)		14. Race - Am Black, Wh Specify:	
	atura ical E	ted	15. Decedent	's Education		16a. Dece	dent's Us	uaf Occup	ation	ost of worki		16b. Ki	nd of Busines	s/Industry
	Hygiene. other then "rent, I'm Med	Somple	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Mach:	DO NOT	use retired	during mid	osi or worki	ng	Сорг	oer Ref	ining
	d oth	Be	17. Father's Name (First, Middle, I								First, Middle,		Surname)	
	Ind Mental Ind Mental Ind Mental Industries	2	Ernest Otto Ma 19a, Informant's Name/Relationsh			19b Maifir	a Addros	s /Street			th Back		r Tours State	Tin Code)
	alth an 27 is n		Liz Malin/Daugh							Drive			town, state,	
	nent of Hea net: If Item:		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (Sp.	3 ☐Removal from State	- 1	lace of Dispo	natory or	ame of other plac	э)		Date	20c. Lo	cation - City o	r Town, State
	Departm Importa any inju	Ì	21. Signature of Fundfal Service		11101	22	Name a	ind Addre	ss of Fac	lity	of MD			MD
	88258		Edward A	Gregorchik			295"	rede	rick	iety Roac	l Balt	imoi	re, MD	21228
E	hysician /Medical Examiner	al Examiner	fmmediate Cause (Finaf disease or condition resulting in death) Sequentially list conditions, and the sequentially list conditions, and the sequential list conditions, and the sequential list cause. (Disease or injury that initiated events resulting in death) Last	a. PROSTA Due to (or as b. Due to for as c. Due to (or as	a consequa	uence of):								
	ripsivan. The law requires that the deall certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	d	2 Fetel	death 3	Ectopic p	pregnancy				2	23d. Date of de	Day Year
4	ned by the a	Phys	9 Unknown	9□ Unknown							T			
	been signed should be det	ted by	Part II. Other significant conditio	ins contributing to death b	ut not resi	ulting in the u	nderlying	cause giv	en in Pan			es 2[to the cause of death? Probably 4 Munknown
1	ate has be	Completed									24a. Was autop perfor 1 🗆 Yes	sy med?	prior to death?	utopsy findings available completion of cause of s 2□ No
Ohmeleden	Sertific	Be	25. Was case referred to medical examiner?	Hospital:				Oth			(Check only o			
1	a e e	ition: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date of Inju (Month, Da		ER/Outpatien 28b. Time of Injury		28c. Injun			me 5 🗌 Resid 28d. Describe h			HOSPICE
	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could n 4 Homicide determi	28e. Place of fni building, et	ury - At ho c. (Specify	me, farm, str	eet, facto	ry, office			28f. Location (S City or Tow			iural Route Number,
	n 24 hour he Funera	Medical	29a. Certifier 1 Certifyin (Check only one) 1 Medical I	g Physician: To the best Examiner: On the basis of and manner sta	of my kno f examinat ated.	wledge, death ion and/or in	occurred vestigatio	d at the tin	ne, date a	and place, a	and due to the ded at the time, d	ause(s)	and manner a place, and du	s stated. e to the cause(s)
	To T Com	Σ	29b. Signature and title of certifier) n_			29	DL	o number	25		29d. Date	e signed (Mon	th, Day, Year)
	5		30. Name and address of person of the second					RD	ттм	ОИТИМ	, MD 21	/ 003		

State of Maryland / Department of Health and Mental Hygiene? For State Amend Items#20a,b,c perFHG828 2/3/200 effificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Mamaril, Sr. JANUARY Benjamin Vergara 2004 5:50A /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Saint Joseph Medical Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 5, 1926 9. Birthptace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Philippines 10 M 20 F 77 215-27-2866 Director Usual Residence of Decedent deeth with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir than "natural", or Itama 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes XX No Director Maryland Baltimore Lutherville 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 1519 York Road 21093 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours atter and of Health and Mental Hygiene. The rest of the rest of the than "natural; or file any or other traumatic aven, the Medical Essential 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1X Yes 2□ No Specify: Specify. δ Filipino 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coltege (1-4or 5+) Clerk Convenience Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ٩ Candido Mamaril Luisa Vergara 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ku Sister 8340 Tally Ho Road Lutherville, Maryland Lilia Date Unk Place of Disposition (Name of Unk cemetery, crematory or other place) 20c. Location - City or Town, State Balt, MD 20a. Method of Disposition Unk-1 X Bunal 2 ☐ Cremation 3 Removal from State permit. Page Department of Important: If any injury or Dulaney Vall MEM Gardens 1/31/04 Timonium Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Eureral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Car Towson, Maryland 21204 tagan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE OBSTRUCTION PULMONARY DISEASE /Medical Due to (or as a consequence of): Examiner RECURRENT PNEUMOTHORAX Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner use as the burial-transit The law requires that the death certificate be executed ENTEROCOLITIS C/DEFICULE that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ② No 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 1 Yes Attanding Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only on Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၀ 2 ER/Outpatient 3□ DOA 1 Yes Inpatient this 28a. Date of Injury (Month, Day Year) 27. Mannet of Deat 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Alter Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 \accident investigation hours after deat 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ö To the Hospitel o within 24 hours aff To the Funerel Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Emano D 24710 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARMANDO A. REAL M. D ... OSLER DRIVE, TOWSON, MARYLAND 21204 7621 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

	Sta	te of Maryland / Depa <i>Cen</i>	rtment of Health and N	Mental Hygiene Reg. No.	004 01886
	Decedent's Name (First, Middle, Last)			2. Date of Deeth	3. Time of Death
Physicia		5020		Month Day	3/ / / 3/7 / M
/Medic Examin	4. Facility blome (If not institution, size atreats	nd number)	4b. City, Town, or L	ocation of Deeth 4c.	County of Death
Examini	NORTHWEST HOSTI	TAL CENTEN	RANDALL	STOWN (BAZTIMORE
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. lest birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Dey, Yeer) JAN . 2,1	9. Birthplace (State or Foreign Country) 929 NEW YORK
Director	225 36 4556 1 ⁻¹ x ^{M 2l}	75 Yrs.	Months Days Hours Min.	JAN. 12,1	929 NEW YORK
2	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	otion		10d. Inside City Limits
eryle aho					1 ☐ Yes 2 🖫 No
the M	MD BALTIMORE 10e. Street end Number 3.5.1.0 VECTION DOAD	DALITI	10f. Zip Code	10a Citi	zen of What Country?
within 72 hours effer death with the Meryland ene. than "natural", or items 23e or 28e-f show he Madical Examinar must be notified at	3510 KESTON ROAD		21207		J,S. OF A.
effer death w or frema 23a	65		as Decedent of Hispanic Origin? (Sp		14. Race - American Indian,
iter d	Arm 1 Never Merried 2 Married 1	ned Forces?	Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
Just of Line	3 Widowed 4 Divorced Yes	Yes 212 No es, Give 1 ar or Detes:	☐ Yes 🌠 No Specify:		Specify: BLACK
72 hours natural',	15. Decedent's Education	16e. Decede	ent's Usual Occupation	16b. Ki	nd of Business/Industry
4 th	(Specify only highest grade comp Elementary/Secondary (0-12) Col	lege (1-4or 5+)	ind of work done during most of work O NOT use retired)	ang	
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ine, intally latter K.1.K. s. 1 and 2 should be filed with! f. Heelth and Mentel Hygiene. Item 27 is marked other than other traumatic event, the M	19a. Informant's Name/Relationship (Type, Prin		Address (Street and Number or Rui		
m 27	LINCOLN PERSON (BR	20b. Place of Dispos			MARYLAND 21207 cation - City or Town, State
Peges 1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova	cemetery, crem	atory or other place) REMATORY 1/20/0		ONSVILLE, MD
tmen tmen tant:	4 Donation 5 Other (Specify)	TIBIRO CI		O4 CATC	NOVILLE, NO
pemit. Pages Depertment of Important: If I any Injury or price.	21. Signature of Funeral Service Licensee	T. GWYNN	Name and Address of Fecility LEWIS T. GWYNN	FUNERAL H	IOME 21215-6393
- 40244	Lewes Tel	reserved 451	7 PARK HEIGHTS		BALTO., MD.
Physician /Medical Examiner	resulting in death)	TERIDS CLERUS IL Due to (or as a consequ	CARDIDVASCULA		Interval Between Onset and Death
cete be executed physicien end the burial-transit	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying	Due to (or as e consequ	ence of):		
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deeth deeth d for	Part II. Other significant conditions contributing	g to death but not resulting in the un-	derlying cause given in Pert t.	23b. Did tobacco	use contribute to the cause of death?
thet the ed by the deteche	Part II. Other significant conditions contributing			1 🗆 Yes 2	□ No 3 □ Probably 4 Ø Unknown
To the Hospital or Attending Physician: The lew requires that the death certific within 24 hours after deeth. To the Functal Director: After this certificate has been signed by the ettending picompletely filled in by the funeral director, page 2 should be deteched for use as it.				24a. Was an autop performed?	24b. Were autopsy findings available prior to completion of cause of death?
The I				1 □ Yes 2	ŽNo 1 ☐ Yes 2 ☐ No
artific ector,	25. Was case referred to medical			th (Check only one)	
hysic his c	1 ☐ Yes 2 ☐ No Hospital	1 Inpatient 2 EH/Outpatient		ome 5 Residence	
Ing P	1 Natural 5 ☐ Pending	Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury et Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injur	y occurred
ttend deeth ttor:	2 Accident investigetion 3 Suicide 6 Could not be	Plece of Injury - At home, farm, stre		28f. Location (Street en	d Number or Rural Route Number,
affer of A	4 Homicide determined	building, etc. (Specity)	or, ractory, office	City or Town, Stete	
Hospital 4 hours Funeral tely filled	29a. Certifier (Check only 2 Medical Examiner: On	To the best of my knowledge, death the besis of examination and/or inve			
thin 2 the	29b. Signature and title of certifier	d menner steted.	29c. License number	29d. Dat	e signed (Month, Day, Year)
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'n		d source of death (from 1994) (Time 1	S V V Z / V	13/70	-MR 7 17, CVV 1
J	30. Name end eddress of person who complete	540) 010 CDV	MS RUAD, RAMO	AZZSKOWN.	MARYLAND 21133
Stat	31. Dete filed (Month, Day, Year)	32. Registrer's Signeture	,)	
Registra	JAN 2 7 2004	See So los	Ochri		

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2001 0535 M Januar 20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner If Under 24 Hrs. 6. Sep If Under TYéar 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace **Funeral** Days 1 M 2 F Min 215-14-71.94 Yrs. Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28e-f show other traumatic event, the Medical Examinar must be restitive at 1 ☐ Yes 2 📉 No Jak Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 202 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No tf Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritat Status 1 Never Married 2 Married 1 Yes 2 No Specify: Wille 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed, d 2 should be filed within 7: th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 ☐Removal from State Mary'S (h. Ce Me : 22. Name and Address of Facility Evans Face) * 4 ☐ Donation S☐ Other (Specify) 21. Signature of Funeral Pervice Micense FOREST 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Finat disease or condition resulting in death) ongestive Physician hear 10 years /Medical Due to (or as a consequence of): Examiner heart au Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ed by the attending physician and detached for use as the burial-transit Wiric bstuc Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown ate has been signed by page 2 should be detach Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has autopsy performed? 1 Yes 2 1 No of Vital 25. Was case referred to medical 26. Place of Death Check on one examiner Other: 1 Hipatient 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Hospital or Attending Injury 1 Watural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) MO 2004 20,

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12. Registrar's Signature

		State of Maryland / De	ertificate of Death	ı Mental Hygle Reg.	CUU4 01000	
	Division	1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Deat	h
	Physician /Medical	Earl Raymond Parrott Jr.		January 2	Day Year 22, 2004 4:14 AM	Л
7	Examine	4a Facility Name (If not institution, give street and number)	4b. City, Town,	or Location of Death	4c. County of Death	
		4205 Penn Avenue	Perry Ha	11	Baltimore	
_	Funeral	5. Social Security Number 6. Sex 7, Age (In vrs. last birthda	y) If Under 1 Year If Under 24 F	Irs. 8. Date of Birth		eian
	Director	212-36-4545 121M 2□ F 65 Yrs.	Months Days Hours M	in. (Month, Day, Ye	9. Birthplece (State or Fore Country) Maryland	J. J.
	-	Usual Residence of Decedent		502. 21,	1990 Haryrand	
	ylan	10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Lim	nits
	Mar 1	Maryland Baltimore Perry Hal	1		1 □ Yes 2 🛣	No
	vith the Mar or 28a-f s be notified	10e. Street end Number	10f. Zip Code	10a	Citizen of What Country?	
	ath with the Marylar 23s or 28s-f show Lat be notified at	4205 Penn Avenue	21236	US		
	72 hours after death with the Maryland natural', or flems 23a or 28a-f show dical Evanified at the control of t				14. Race - American Indian,	
	fler dea	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Never Married 2 □ Married 1 ☑ Yes 2 □ No	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	erto Rican, etc.)	Black, White, etc.	
8	al', or frema Evamination by Funal	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates: 1956–59	1 ☐ Yas 2 No Specify:		Specify: White	
ŏ	tura	15. Decedent's Education 16a. Dec	edent's Usual Occupation	401		
15	ed within 72 horygiana. Ner than "naturalt, the Medical E.	(Specify only highest grade completed) (Git	re kind of work done during most of v DO NOT use retired)	vorking	b. Kind of Business/Industry	
7	withir ana.	Elementary/Secondary (0-12) College (1-4or 5+)	roller and Treas		mark Duadana	
2		17. Father's Name (First, Middle, Last)		lame (First, Middle, Maid	port Business	
an	B gg B	Earl Parrott				
Ž	should ind Men ind Men ind Men ind individual individua			adeline Spr		
8	l 2 sho l and ls mar raum		ling Address (Street and Number or	Rurel Route Number, Ci	ty or Town, State, Zip Code)	
ď	Haaith Haaith em 27	Mary E. Iwancio / daughter 4205	Penn Avenue Peri	ry Hall, Ma	ryland 21236	
5	of H fite or ot	20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State 20b. Place of Discemetery, completely,	osition (Name of ematory or other place)	January 20c	. Location - City or Town, State	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should Department of Haalth and Mer Important: if item 27 is marke any injury or other traumatic page.	4 □ Donation 5 □ Other (Specify) Bayview	Crematory, Inc.	24, 2004 B	altimore, Maryland	
a	permit. Departr Imports any Inj	21. Signature of Funeral Service Licensee	22. Nama and Address of Facility Oing Home Cremati	ion Commiss	P 0 P - 70/	
m	89 = 28	150101/1 1 Half H MO1251 B	ororly I Hodros	ton Service	larksville, MD 210	20
		23a, Part1. Enter the disease, or complications that caused the death. Do not e	nter the mode of dving such as card	ac or reeniratory arrest	Approximate	29
	Physician	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	the trie mode of dying, odon do data	as or respiratory arrest,	Interval Between Onset and Death	
1	/Medical	Immediate Cause (Final	1 0		,	
	Examiner	Immediate Cause (Final disease or condition resulting in death) e. Esophogea			1.41	
	d die	Due to (or as e cons	equence of):			
	icate be axecuted physician and s the burial-transit edical Examiner	b	<u> </u>		1	
	ifficate be axecuted g physician and as the burial-transit ledical Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consection).	equence of):		1	
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87	phys the	resulting in death) Last Due to (or as a conse	quence of):			
	5 0 6 E	d				
Box	The law requiras that tha daath cent ate has been signed by the attendingage 2 should be datached for use completed by Physician/N					
o	the the hed	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23b. Did tobac	co use contribute to the cause of deat	h?
o .	d by latac			1 🗆 Yes	2 No 3 Probably 4 Unkno	own
Vital Records,	as the digner be d			-		
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		25. Was case referred to medical	26 Place of De	eath (Check only one)	1210 2210	_
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Division of		27. Manner of Death 28e. Date of Injury 28b. Time		28d. Describe how in		1/4
<u></u>	the fire the	1 X Naturel 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
135	ital or Attending P is aftar death. al Director: After t led in by tha funers Certification:	3 Suicide 6 Could not be 28e Place of Injury . At home farm s	reet, factory, office	28f. Location (Street	and Number or Rural Route Number,	_
É	afta afta	4 Homicide determined building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town, Sta	afe)	
	Political Series of Filler	29a. Certifier Check call. Certifying Physician: To the best of my knowledge, dea	h accurred at the time data and at-	on and due to the con-	(a) and manner	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by tha ti Medical Certificati	(Check only one) Check only one) Check one) Check only one) Check only one) Check only one) Check one) Check one) Check one) Check one) Check one) Chec	evestigation, in my opinion, death occ	curred at the time, date a	(a) and manner as stated. Ind place, and due to the cause(s)	
	ithin of the omple	29b. Signature and title of certifie	29c. License number	294 [Date signed (Month, Day, Year)	
	F 3 F ŏ	b. B. Anenle und				
	_ \/	July John y	D18287	Janu	ary 22, 2004	
	101,	30. Name and address of persur yno completed cause of death (Item 23a) (Type	Print)	R	10-12 - 12-0	,
صور	\	TAUL GORMLEY 700 CI	TON AUE	1>ALTIMO	ME MD 21229	
	State Registrar	31. Dete filed (Month, Day, Year) 004	alle s		,	

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Edward S. Peddicord 0851 AM January 24 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hane None are If Under 1 Year Months Days If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Min. Hours M 2 ☐ F 218 12 8117 80 Director 17, 1923 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Health and Mental Hygiene. Item 27 Is marked other than "naturel", or Items 23s or 28s-1 ehow other traumatic event, the Medical Examiner must be notified at 10a. Stale 10b. County 1 ☐Yes 2X No Director MD Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 715 Maiden Choice Lane CC609 United States Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? be filed within 72 hours after 1 Syes 2 No If Yes, Give Year or Dates: 1943-45 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Maryland 21215-0036 Specify Specify 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mortgage Appraiser Banking 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Robert James Brent Peddicord . Pages 1 and 2 should be thent of Health and Mentatent: If item 27 is marked Helen Elizabeth Carr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 715 Maiden Choice Lane CC609 Catonsville, MD 21228 Doris S. Peddicord/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Depertment of Important: If ony injury or Good Shepherd Cem. 1-29-2004 Ellicott City, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 21. Signature of Funeral Service Licenses Col 4112 Old Columbia Pike Ellicott City, MD 21043 Dani 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final respiratory Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 290 pneumonia Community fany, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequ Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 Yes 2 No detached o 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, pe heart failure. 3 ☐ Probably 4 Unknown 1 ∏ Yes 2 ∏ No disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 2□ No 1 Yes 1 Yes 2 No Vital ector, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: spital: 1 Inpatient 2 28a. Dale of Injury (Month, Day Year) Other: ပို 1 ☐ Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specity) 2 ER/Outpatient 3 DOA ot 27 Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Division or Attending 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No death. investigation 2 Accident filled in by the within 24 hours after deatl
To the Funerel Director:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital TE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 60 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 90 31. Date filed (Month, Dan) 32. Registrar's Signature Day Year) State The state of Registrar

DHMH 17 Rev 1/2001

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			For State Registrar	State of Man		artment of He ertificate of D	ealth and Mer <i>leath</i>	ntal Hygien Reg. N	Car Co Co T	01890			
			Decedent's Name (First, Middle, La	ist)				Date of Death Month D	V	3. Time of Death			
	Physici		Catherine	1001	2			Month D	ay Year ≿U. S∋∪4	7.32 AM			
	/Medic Examin	_	4a. Facility Name (If not institution, given North West H	ospital	Ctr.	4b. City, Town, or L	ocation of Death		4c. County of Death BOLLIMOYC				
	Funeral Director			Sex 7. Age (/ 1 ☐ M 2 🛣 F	n yrs. last birthday 76	Months Days	Hours Min.	(Month, Day, Year	r) Coun	lace (State or Foreign try) MD			
			Usual Residence of Decedent										
	arytan ehow d el	_	10a. State 10b. County MD Balti		0c. City, Town or L	ocation Pikes	villo		1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No			
	he Mi	Director	10e. Street and Number	IMOTO		10f. Zip Code	VIIIC	10a. C	itizen of What Coun				
	with March		717 Cloudyfold	Drive			208		USA				
	death	Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.	Was Decedent of His	panic Origin? (Specify , Mexican, Puerto Rica	Yes or No-	14. Race - Americ				
336	72 hours after death with the Maryland natural', or items 23a or 28a-1 ehow Jical Examinar nust be notified at	ò	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 21 No	Specify:	in, 6tc./	Black, White, Specify: Wh	ite			
21215-0036	i within 72 hours jiene. r then "naturel", tre Medical Ex.	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Giv	edent's Usual Occupat e kind of work done du DO NOT use retired)	ion uring most of working	16b.	b. Kind of Business/Industry				
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	othe	BeC	17. Father's Name (First, Middle, Las	<i>t</i>)	,		18. Mother's Name (Fi	rst, Middle, Maide	n Sumame)				
ylar		10.	Jeremiah P. McCa				Agnes C. 1						
Maryland	and and is m	v I	19a. Informant's Name/Relationship				nd Number or Rural Ro			Code)			
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nor	ages anf of it: If it y or o		1 XBurial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Special	timore. MD									
altimore,	permit. Pages 1 Department of t Important: If ite any injury or ot once.		sterstown										
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	/Medical Examiner		resulting in dealiny	Due to (of as a c	onsequence of):								
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8760,	cate b	dical		d									
.O. Box 6	The law requires that the death certific the has been signed by the attending to agge 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Wo 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 [4 ☐ Pregnant at tin	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ory Day Year			
Φ.	ires that signed b d be deta	þ	Part II. Other significant conditions	contributing to death but r	not resulting in the	underlying cause giver	n in Part I.	23e. Did tobacco	use contribute to th	i			
Records,	ie law require has been si ge 2 should b	Completed						24a. Was an autopsy performed?		psy findings available inpletion of cause of			
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Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	a∏5500	Other	26. Place of Death (Ca		A Florit (0)				
of	Phys this raldi	1: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a, Date of Injury	2 ER/Outpatie	MIL 3 DOA	4 Indising Home	Describe how inj		/)			
ion	Attending Phist death. ector: After this by the funeral	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Day Y	ear) Injury		es 2 □No						
Division	I or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 6 Could not determined		28f.	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
_	To the Hospitel or At within 24 hours after d To the Funerel Direct completely filled in by	Medical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of a miner: On the basis of ex and manner state	camination and/or i	ath occurred at the time nvestigation, in my opi	e, date and place, and nion, death occurred a	due to the cause(at the time, date an	s) and manner as st nd place, and due to	ated. the cause(s)			
	To th within To the	Me	29b. Signature and title of certifier			29c. License	number	29d. D	ate signed (Month,	Day, Year)			
			Alik H	sim		1-14	3974	Tan	ion, 24	204			
	1,3		30. Name and address of person who	completed cause of dea	th (Item 23a) (Type	Print)	1 120	10.11.40	ha han	er kad			
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			For State Registrar	State of	Marylan		artmen rtificate			and M	lental Hyg	giene) Reg. No.	004	01891		
F	Dhusiai	0.00	1. Decedent's Name (First, Middle, Last								2. Date of Dea Month JAN. 2	Dav	Yeer	3. Time of Death		
	Physici /Medic		Fitchael Stephen Powell										004	4:30a M		
8	Examin	er	4a. Facility Name (If not institution, give 7 Magruder Avenu		ber)				Location on nsvi]			4c. Col	unty of Deeth			
)		. Age (In yrs.	last hirthday)	If Under		If Under		8. Date of Birtl	1	Balti 9. Birth			
	Funeral Director		213-56-0256	x]M 2□F	53	Yrs.	Months	Days	Hours	Min,	8. Date of Birth (Month, Day JUL 29,	1950		place (State or Foreign intry) York		
	ס		Usuef Residence of Decedent										_			
	urylen show	_	10a. State 10b. County		10c, Cit	ry, Town or Lo							i	10d, fnside City Limits 1 ☐ Yes 2 No		
	Ba-f	cto	Maryland Baltim	ore		Ca	atons		e		-	10a Citizan	log. Citizen of What Country?			
	with the	Ö	10e. Street and Number 7 Magruder Avenue 21228									rog. Onizen	USA			
	ns 23	eral	11. Marital Status	12. Was Deced	tent Ever in U	.S. 13. 1	Was Deced			gin? (Sp	ecify Yes or No- Rican, etc.)	14.	Race - Amer			
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hyglene. Depertment of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show spirity or other traumatic event, the Medical Examinal must be multified at ODGs.	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2X□No			lf Yes, spec 1 ☐ Yes :		n, Mexican Specify:	i, Puerto	Rican, etc.)	Ì	Bleck, White ec <i>ity:</i> Wh	, etc. ite		
Š	2 hou	ted	15. Decedent's Edi	ication		16a. Dece	dent's Usua	al Occupa	ation	t of work	ina	16b. Kind o	d of Business/Industry			
2	e. an "n	Completed	(Specify only highest grad Elementary/Secondary (0-12)		College (1-4or 5+)				luring mos	o work	""					
7	e filed will Hygien other th	Co	47 Salada Nama (Sina Middle Local)			Edite	or/Jo	urna.		r'e Name	e (First, Middle,		ewspap	er		
Maryland 21215-0036	od otl	Be	17. Father's Name (First, Middle, Last) Roland Alvah Pow	e11							largaret					
يَ	should nd Me mark matic	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or													
	nd 2 salth ar 27 is r trau		Anne P. Powell/wi	fe		. 7	Magn	uder	Aven	ue	Catonsv	ille,	MD 21	228		
ē.	of Hei		20a. Method of Disposition 1 Burial 2 Oremation 3			Place of Dispo	natory or o	ne of ther place	9)	(Date	20c. Locati	ion - City or T	own, State		
Ē	Page nent c		1 ☐ Bunal 2 ☑ Cremation 3 ☐ 1 1 ☐ Donation 5 ☐ Other (Specify,		Me	tro Cre	emato	ry,	Inc.	1/26	6/04	Bal	timore	, MD		
Baltimore,	permit. Depertr Importa eny inju		21. Signature of Funeral Service Licenses MacNabb 22 MacNabb Funeral Home, P.A. George E. MacNabb 301 Frederick Road Catonsville, MD 21228											21228		
	秦建 李		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that ca	used the deat ch line.									Approximate Interval Between		
Pł	Physician		Immediate Cause (Final disease or condition Esophageal Cancer											Onset and Death		
ā	/Medical Examiner		Due to (or as a consequence of): [
В		- Br	Sequentially fist conditions,	Due to (or as a consequence of):												
	uted d ansit	Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events													
ó	exection and and rial-tra		resulting in death) Last	Due to (d	r as a conseq	juence of):										
8760,	icate be executed physicien and s the burial-transit	ical		d												
9	death certificate be executed e ettending physicien and id for use as the burial-transit	Med	IF FEMALE:											7		
Вох	eath certif ettending for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)								23d.	Date of delive Month	Day Year		
0		ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown												
<u>α</u>	og og	by	Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to													
Records,	v requii been s should	Completed									24a. Was	an 2	4b. Were aut	opsy findings available		
Rec	The lay	dmo									autop perfor	sy med?	prior to death?	empletion of cause of		
Vital		a)	25. Was case referred to medical		26 Place of C					of Deat	1 ☐ Yes	2XINo	1 🗆 Yes	2 NO		
	dis y	OB	examiner?	Hospital: 1 🗌 Ir	patient 2	ER/Outpatier	nt 3 DC	Othe) F	ırsing Ho	14141		Other (Speci	fy)		
0 0	ng Phys ter this neral di	n: T	27. Manner of Death 1 Natural 5 ☐ Pending							28d. Describe h	ow injury oc	curred				
Sio	Attending r death. sctor: After y the fune	catle	2 Accident investigation				М		Yes 2□	No	2011			1.7		
Division of	or At after d Direct in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined		of Injury - At h g, etc. (Specil		eet, factory	/, office			City or Tow	n, State)	umber or Hui	al Route Number,		
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	ledical Co		ing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Il Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	To the within 2 To the complet	Mec	29b. Signature and title of/certifler	-//			290	c. License	number				gned (Month			
	- s - ŏ		I last Josh	ula /	np			11	85	87	2	JAN	22	2004		
	10		30. Name and address of person who of	ompleted cause	of death (Iter	п 23а) Туре.	Print)	Allie	- 1	BAD	TT MORL	= Mi	D .	2004		
	Sta		31. Date filed (Month, Day, Year)	32. Re	egistrar's Signa	atur	Anna h	1/2		//	11 - 10 - 10	y				
	Registi	ar	JAN 2 7 2004	Andread	/	1-	- Con	-								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20:07 **Physician** Year Maude E. Provins anuary 19 /Medical 4a. Facility Name (If not institution, give speet and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Sinai Kospital of Baltimore Baltimore N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March B, 1918 **Funeral** 9. Birthplace (State or Foreign 1 ☐ M 2 🔀 F Days Hours Mississippi Director <u>426-01-1607</u> 85 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits other than "natural", or items 23s or 28s-f show 1 Tyes 2 No Baltimore Glen Arm Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21057 USA 11630 Glen Arm Road Unit 227 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Ď Specify: 3 ₩ Widowed 4 Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Mental permit. Pages 1 and 2 should be Department of Health and Menta Important: If tiem 27 is marked any injury or other traumstic evonce. is marked 2 Lena Kratzschmar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Teaneck Court; Timonium, MD 21093 Paula E. Lewin daughter Baltimore, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specific) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Dulaney Valley Mem Gardens | 1/23/04 21. Signature Fyera Service Timonium, MD 22. Name and Address of Facility 1050 York Road MD 21204 Ruck Towson Funeral Home Towson. 23a. Part1. Enter the disease, or complicatings that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) intracerebra hemorrhage **Physician** days /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physiclan/Medical P_e for use and 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month signed by the aid be detached for 4☐Pregnant at time of death Day Year P.O. I 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, insulin-dependent 1 Yes 2 No 3 Probably 4 Nunknown peen hypertension certificate has t irector, page 2 s 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2. No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 28d. Describe how injury occurred 1 X Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No the 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director; 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of cedifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 January 19, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mariya F. Da 31. Date filed Month, Day, Year) JAN 27 2004 Hospital of Darland 2. Registrar's Signature State Registrar

			1 - State Amend Item	State of #8 per f	Marvlar	nd / Depa	artmen	t of H	lealth a		lental Hyg		004	018	93			
			1. Decedent's Name (First, Middle	, Last)					-		2. Date of Deat Month	h Dey	Yeer	3. Time of D	leath			
	Physici /Medic		Astrea A. Rector										04	6:00	A.M			
}	Examin		4a. Facility Name (If not institution			ounty of Death												
			The state of the s										ntgome	ry				
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☑ F	7. Age (<i>In yr</i> s. 89	last birthday) Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day,	Year)	Chan	pplace (State or Foreign intry) ttilly, VA.				
	Director		578-20-6985 Usuel Residence of Decedent			110.					01 21	0+	Chan	LIIIy,	VA.			
	land		10a. State 10b. County		10c. C	ity, Town or Lo	ocation							10d. Inside City Limits				
	f ehc	ō	D.C.		7.	ashing	ton							11 Yes 2	2 🗌 No			
	the 28s	Jec	10e. Street and Number			rasiiii <u>6</u>	10f. Zip	Code			1	0g. Citizer	n of What Cou	ntry?				
	3a or	<u> </u>	1424 Webster St	reet N.W.			20	011				US	A					
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or tlems 23s or 28s-f ehow ant, the Medical Evanifier must be notified at	by Funeral Director	11. Marital Status	12. Was Dece		J.S. 13.	Was Deced	lent of H	ispanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	14.	Race - Amen					
9	or Ite	Ē	1 Never Married 2 Marri	Armed For	2 🔀 No		ii res, spec		Specify:	, rueno	nican, etc.)							
ğ	ralf, c	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Da	ates:		TU Tes .	263 140	зреспу.			34	pecify: B1a	CK				
r P	72 ho	Completed	15. Decedent (Specify only highes	's Education		(Give	dent's Usua kind of wo	k done o	during most	t of worki	ing	16b. Kind	of Business/Ir	ndustry				
Baltimore, Maryland 21215-0036	of Paris	npi	Elementary/Secondary (0-12)	College (1-	-4or 5+)		DO NOT us	e retired	1)			*** **						
2	ygier ygier It, III	Co	12th.	f a-4)		CTe	erk		19 Mothe	r's Nome	/First Middle A		S. Government					
Ē	tal H	Be	17. Father's Name (First, Middle,	Last)		18. Mother's Name (First, Middle, Maiden Suma							mene,					
3	should be and Mental marked o umatic eve	ဥ	Henry Allen Geneva Douglas									Canan 3	- Cadal					
ă			19a. Informant's Name/Relations Carl Kaiser	nip (<i>Type, Print)</i> Nephew	,	1	-				ver Spri							
e)	Health Health tem 27 other tr		20a. Method of Disposition	периси		Place of Dispo							tion - City or T					
وّ	or of		1 Burial 2 ☐ Cremation		State	cemetery, crea	matory or o	ther plac		1 26								
Ħ	t. Pa		'4 Donation 5 Other (Specify) Lincoln Memorial Cem. 1-26-04 Suitland											•				
Ba	permit. Pages 1 and Department of Heat Important: if Item 2 any injury or other 2005.		21. Signature of ineral Service	00	1													
	Physician		4217 9th. St. N.W. Washington, D.C. 20011 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Immediate Cause (Final disease or condition) Metastatic Colon Cancer															
760,	/Medical Examiner Asicien and be burial-transit	icai Examiner	Sequentially list conditions, and before to make the cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last	b. ————————————————————————————————————	or as a conse	quence of):												
O. Box 68	at the death certificate to by the attending physic tached for use as the to	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									230	23d. Date of delivery Month Day Year					
rds, P	ires tha signed d be de	by	1 Yes 24a. Was an autopsy performed 1 Yes									co use contribute to the cause of death? 2 No 3 Probably 4 Unknown						
of Vital Records,	The law ate has b page 2 sl	Completed									autops perforn	prior to co death?	ere autopsy findings available for to completion of cause of sath? Yes 2 \(\sum \) No					
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?					0.5		of Death	(Check only on	e)			_			
_	S 0 =	မ	1 ☐ Yes 2 ☐ No			ER/Outpatie			4 🗆 140		me 5 🖸 Reside			fy)				
ב	ding Phy h. After thi funeral	on:	27. Manner of Death 1 X Natural 5 ☐ Pendin	g 28a. Date of (Month)	h, Day Yeer)	28b. Time o		8c. Injur Wor	k?		28d. Describe ho	w injury o	ccurred					
Sio	Attending in death. ector: After by the fune.	cati	2 Accident investig	not be			М		Yes 2 🗌	-								
Division	tal or Attendes safter deatle Director:	Certification;	4 Homicide determ	289. Flace	of Injury - At I ng, etc. (Spec	nome, farm, st ify)	reet, factory	, office			281. Location (St City or Towr		lumber or Rur	al Route Numbe	∌ <i>r</i> ,			
	Hospil 4 hour Funer ely fill	edicai		g Physicien: To the Examiner: On the ba and mann	asis of examin													
	To the within 2. To the complet	Σ	29b. Signature and title of certific		// `		290		e number		,	9d. Date s	igned (Month,	Dey, Year)				
	1		Wrene lo	outato.	is, n	1)		000	57	304	1	1/2	2/04					
	10		30. Name and address of person			m 23a) (Type,	Print)											
_	1		Dr. Eirme Kor															
		ate	31. Date liled (Month, Day, Year)	a	egistrar's Sign													
	Regist	rar	JAN 27	2004	Garrie -	is by	andi)											
DH	MH 17 Rev 1/2	2001				ORIGIN												

		1 - For State Registrar	State of Maryland	l / Depa		lealth and	Mental Hyg		01894		
Physici /Medic	al	Decedent's Name (First, Middle, Li Helen Virginia 4a. Fecility Name (If not institution, gi	Roberts		4b. City, Town, or	Location of Dea		Day Year 23 2004 4c. County of Deat	3. Time of Death		
/ Examin	er	Stella Maris			Timoniu	m		Baltimore			
Funeral Director		217-05-4749	Sex 7. Age (In yrs. Ia:	st birthday) Yrs.	If Under 1 Year Months Days	Hours Min.		Year) 9. Birt Co	hplace (State or Foreign ountry)		
deeth with the Maryland me 23a or 28e-f ehow Imust be notified at	lor	Usual Residence of Decedent 10a. State 10b. County MD Baltimo		Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No		
with the sor 28e-	Direct	10e. Street and Number		WSUIT	10f. Zip Code		10	0g. Citizen of What Co	ountry?		
P # 8	by Funeral Director	724 B-1 Camber 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Des 2 No If Yes, Give Year or Dates:	2. Was Decedent Ever in U.S. Armed Forces? If 1 \top Yes 2 \top No If Yes, Give			Specify Yes or No- to Rican, etc.)	USA 14. Race - Ame Black, White Specify: W			
Z1Z15-UU36 ad within 72 hours at glene. er than "neturel", or the Wedleal Exam.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of wo		16b. Kind of Business/Industry			
Maryland 2121: 12 should be filed within 7 h and Mental Hyglene. 7 is marked other than "reaumatic event, the Med	Be	12 17. Father's Name (First, Middle, Las Harry Johnson	n/a	CI	erk		Railroad Maiden Sumame) Armstrong				
Maryland of 2 should be file lith and Mental Hy 27 is marked oth traumatic event	၉	19a. Informant's Name/Relationship				and Number or R	ural Route Number,	City or Town, State, 2			
Saltimore, Mi permit. Peges 1 and 2 Separtment of Heelih a mportent: If item 27 is any injury or other tra ang.e.		B. Donald Scheck/nephew 13948 Jarrettsville Pike, Phoenix, MD 21131 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 14 Donation 5 Other (Specify) 13948 Jarrettsville Pike, Phoenix, MD 21131 20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cem. 1/27/04 Baltimore, MD									
Dalitimor permit. Peges : Department of H importent: If ite any injury or of once.		ulaney Val ium, MD 2	y Valley Inc.								
Pnysician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, a. Due to (or as a possible of the conditions, if any, leading to immediate cause. Enter Underlying) Due to (or as a consequence of the conditions)										
ate be executed anysicien and he burial-transit	icai Examiner	Cause (Disease or infury that intitated events resulting in death) Last	c	ence of);							
the death certificate I the death certificate I was the attending physisched for use as the the the the the the the the the the	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 22□ Ne 9 □ Unknown	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetel d 4 ☐ Pregnant at time of dea	leath 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year				
hat d b	d by Pl	Part II. Other significant conditions		id tobacco use contribute to the cause of de							
ne law has b	ompiete	Fre OF BEA	3/10/cas			24a. Was an autopsy perform	ed? death?	topsy findings available completion of cause of			
VICAL F	To Be C	25. Was case referred to medical examiner?	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
ath.		27. Manner of Death Death Solution Pending Investigation	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injury Work M 1 🗆 Y		28d. Describe how injury occurred				
To the Hospitel or Attending Physicien: The within 24 hours alter death. To the Luneral Director: After this certificate completely filled in by the funeral director, pa	Certification:	3 ☐ Suicide 6 ☐ Could not I determined	building, etc. (Specify) 258. Place of Injury - Actione, farm, street, factory, office City or Town, State)								
the Hosp hin 24 hou the Fune npletely fil	Medical	(Check only 2 Medical Exa	hysician: To the best of my knowledge: On the basis of examination and manner stated.			pinion, death occu	urred at the time, da	te and place, and due	to the cause(s)		
	-	29b. Signature and title of certifier	harts u	->	2.9C. License	S S S	29	29d. Date signed (Month, Day, Year)			
jo		30. Name and address of person who $EDDIE\ NAKHUDA$, M			Print) VALLEY R	OAD TI	IMONIUM 1	MD 21093	er en en en en en en en en en en en en en		
Sta Registr		31. Date filed (Month, Pay, Year)	32. Registrar's Signatu	Anna	E)						

6:01 A.M.

JANUARY 23, 2004

ROBERTS, HELEN

		For State Registrar		State of	Marylan	-	artment <i>rtificate</i>			and M	iental Hy	giene Reg. No	600	4	01895	
		Decedent's Name (Firs	t, Middle, La	st)			•••				2. Date of De Month	ath Dav	y Y	ear .	3. Time of Death	
Physici /Medio		Clayton	Jame	s R	eynolds	5					Januar	y 24	<u>1, 200</u>	4	1:20 am M	
Examir		4a. Facility Name (If not in	stitution, giv	e street and nun	nber)		4b. City, T	own, or	Location o	of Death		4c.	. County of I	Death		
		Heritage N				to a totale de	Dund If Under 1		If Under 2	24 Hre	a Data of Bi	Ba	altimo	re	(Ct-to-or Foreign	
Funeral		5. Social Security Number	_ 1	ex Mi 2□F	7. Age (In yrs.	iast biπnday, Yrs.		Days	Hours	Min.	8. Date of Bill (Month, Da	ay, Year)	9.		ace (State or Foreign try)	
Director		215-12-125 Usual Residence of Dece			80						8/3/19	123		Mar	yland	
/land			County		10c. City	y, Town or L	ocation							10	Od. Inside City Limits	
the Maryland r 28e-f show notified at	ţċ	Maryland	Baltin	ore	Ess	sex									1 ☐ Yes 2 🛣 No	
or 286	Director	10e. Street and Number					10f. Zip (Code				10g. Cit	tizen of Wha	t Coun	try?	
th wit	a	810 Briarh	ill Pl	ace			212	21				U.	S. A.			
72 hours after death with the natural', or items 23e or 28e Iteal Examinational be not	Funeral	11. Marital Status		12. Was Dece Armed For		.S. 13.	Was Decede	ent of Hi fy Cuba	spanic Orig	gin? (Sp.	ecify Yes or No Rican, etc.)	0-	14. Race - Black, 1			
or it	y F.	1 Never Married 2		1 V Yes If Yes, Giv	2□No 19	943	1 Yes 2	X No	Specify:				Specify:			
ural,	d by	3 Ndowed 4 □ D		Year or Da	ates: 1 S	162 Door	dent's Usual	Occupa	ation			16h K	ind of Busin		hite	
- 68	Completed	(Specify on		ade completed)		(Give	kind of work	done a	lurina most	t of work	ing	100.10	and or busin	1033/11/0	lustry	
then.	mc	Elementary/Secondary 10	(0-12)	College (1	-4or 5+)	Stee	l Work	er	,			Ret	hlehe	m S	teel	
tal Hygiene. Id other then event, Ite M	C	17. Father's Name (First,	Middle, Last)		, DCCC.			18. Mothe	r's Name	e (First, Middle	•				
± 0 €	To Be	Steven	Reyno	olds.					Ella		Hofmei	ster	-			
and Menta Is marked sumatic ev	-	19a. Informant's Name/F		Type Print)		19b. Mail	ng Address	(Street a			al Route Numb			te, Zip	Code)	
27 Is		George Irv	ing Th		other)	824 1	woodro	v Ar	venue	Es	sex, Ma	rvla	and 21	221		
yes I and 2 should t of Health and Men If item 27 Is marke or other traumatic		20a. Method of Disposition	n			Place of Disp	osition (Nam	e of	7	1	Date		ocation - Cit		wn, State	
ent of nt: If if		1 ∰Burial 2 ☐ Cre '4 ☐ Donation 5 ☐ €			State	olly H				1/ 20	04	Balt	imore	. M	aryland	
Department Important: any injury once.		21. Signature of Funeral			110	2	2. Name and	Addres	s of Facilit	y				7		
Depar Impor any ir		Michael	0	Sallin	~ 5r.		1407 o	ld E	Caste	rn A	l Home venue	Esse	ex, Ma	ryl	and 21221	
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw.												Approximate Interval Between		
hysician		Immediate Cause (Final disease or condition A THEROSCLEROTIC CARDIO WAS GIPLAR											Onset and Death			
/Medical		resulting in death)	•	Due to (or as a conseq				<u> </u>		DISER	SE				
xaminer		Sequentially list condition	15	b. DIAK	SETE	SA	1664	14	65							
Ħ	iner	Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury	ate 2	Due to (or as a conseq	juence of):								ĺ		
and I-trans	Examiner	that initiated events resulting in death) Last	1	CMAL	NU/	X//	16N									
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physici the bu	dicai		•	d)//	1200	1 (VIP										
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e has	E E										auto perf 1 Yes	ormed?	prio	r to cor th? Yes	psy findings available inpletion of cause of 20 No	
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erthis eraldii	l :	27. Manner of Death			of Injury th, Day Yeer)	28b. Time		Bc. Injury Work			28d. Describe					
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actor by th	iţi	3 ☐ Suicide 6 [4 ☐ Homicide	Could not to determined	280. Place	of Injury - At h	ome, farm, s	treet, factory,	office			28f. Location City or To			or Rura	l Route Number,	
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within 24 hours after death, within 24 hours after death, and to the Funeral Director. After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier 💢	Certifying P	hysicien: To the	best of my kno	owledge, dea	th occurred a	it the tim	ne, date an	d place,	and due to the	cause(s) and mann	er as st	ated.	
in 24 the F	edi	one)		and man	ner stated.	2007 200					1					
To	Σ	29b. Signature and title of	of certifier	1.	22.	111	29c.	License	e number	0		29d. Da	ite signed (f	vionin, i	Day, rear)	
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11		30. Name and address o	f person who	completed caus	se of death (Iter	m 23a) (Type	Print)	Dis		1	11.0	-11-	202	7	() 79	
		Saunder	Y 1/2	1 Cillo	-21	1av	er (100	16	1)	cupita	IK.	171	4	1222	
	ate	31. Date filed (Month, Da	7 200		legistrar's Signa	ature La	1									
Regist	rar	OHIYA	* ZUU	4 /22	As a second	127	Ann	100								

sician and burial-transit The law requires that the death certificate be executed P.O. Box 68760, as the use Division of Vital Records,

Rosenbaum

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 22 2004 Month 1242 **Physician** ROSENBAUM January /Medical 4c. County of Death 4b. City, Town, or Location of Death 4e. Facility Name (If not institution, give street and number) Examiner Sinai Hospital of Baltimore Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) DEC. 28, 1918 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🙀 F 220-07-3902 85 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No BALTIMORE Director BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 U.S.A. 712 LEAFYDALE TERRACE or items 23a Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 □Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: WHITE 3 ¥ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be finent of Health and Mental Pant: If item 27 is marked of BUTLER (UNKNOWN) FANNY JACOB 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MICHAEL ROSENBAUM / SON 1506 ELM STREET - EL CERRITO, CA 94530 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 4 □ Domation 5 □ Other (Specify) BALTIMORE HEBREW CEM. 1/23/2004 REISTERSTOWN, MD nature of Funeral Service Centee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only only cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Longestive 2 yrs. **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner AURTIL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Certification: To Be Completed by Physician/Medical Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Mellitus 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 NO 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1116 1 Almpatient 2 ER/Outpatient 3 DOA in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \(\text{Homicide} \) within 24 hours aft To the Funeral Di completely filled in To the Hospital Medical 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 0 address of person who completed cause of death (Item 23a) (Type, Print) Hospital of 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 2 7 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	•	For State Registrar	e of Maryland / D	epartment o Certificate o		Re	eg. No.	DIROT
Physicia /Medic	an al		SWINSON			2. Date of Deat Month	Day 5 Year	7 0.37PM
Examine Funeral	er	4a. Fecility Name (If not institution, give street and INNUERSITY OF MAR YLAN 5. Social Security Number 6. Sex	7. Age (In yrs. last birth	day) If Under 1 Ye	n, or Location of Death ALTIMORE ar If Under 24 Hrs. vs Hours Min.	8. Date of Birth APR 2 Day 2	4c. County of Dea N/A	th thplace (State or Foreign Caroli)
Director		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	rs.	<u></u>	APR.Z,Z	NOI	10d. Inside City Limits
he Maryla 28a-f shov	ector	MD. N/A	-	LTIMORE	la .	11	0g. Citizen of What C	1 Yes 2 □ No
ath with the 23a or 2	ral Dir	10e. Street and Number 4630 PIMLICO ROAD		212			U.S. OF	' A.
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filed within 72 hours after death with the Maryland Hygiene. Wher then "natural", or Items 23a or 28a-f show int, the Medical Examinat must be routiled at	Completed by Funeral Director		eted) (egge (1-4or 5+) T. Z	Decedent's Usual Od Give kind of work do life. DO NOT use re ABORER	ne during most of work	ing	16b. Kind of Business	DRY DOCK
uld be filed Aenta! Hygi rked other itic event, I	To Be Co	UNKNOWN 17. Father's Name (First, Middle, Last) UNKNOWN	NOWN		18. Mother's Nam	e (First, Middle, A EDWARD	Maiden Sumame) (DECEASE	ED)
1 and 2 sho Health and em 27 Is mu ther traum		20a. Method of Disposition	(WIFE) 463	30 PIMLI Disposition (Name o		BALTIMO	ORE, MARYI	LAND 21215
permit. Pages Department of Important: If it sny injury or o once.	1	1 Burial 2 □ Cremation 3 □ Removal 4 □ Donation 5 □ Other (Specify) 21. Signature Experies Service	from State CROWNS IS T. GWYNN		ET. CEM.I T. GWYNN RK HEIGHI	FUNERAL	L HOME 21	LLE, MARYI 1215-6393
Physician /Medical Examiner buy sician and street transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Mat caused the death. Do not a on each line. ALLYTHMIA Let to (or as a consequence of the consequence of t	ot enter the mode of				Approximate Interval Between Onset and Death
The law requires that the death certificate has been signed by the attending rage 2 should be detached for use as	Physician/Me	in the past 12 months?	is, outcome of pregnancy Live birth 2 ☐ Fetel death Pregnant at time of death Unknown	3 ☐ Ectopic pregni 5 ☐ Other (specify			23d. Date of de Month	livery Day Year
quires that an signed by uld be deta	þ	Part II. Dther significant conditions contribution SEIZURE DIS	g to death but not resulting in	the underlying cause	given in Part I.		pacco use contribute t es 2 ☑ No 3 ☐ P	o the cause of death?
	Completed						y prior to death?	utopsy findings available completion of cause of s 22470
Attending Physician: The redeath. ector: After this certificate by the funeral director, pag	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Date of Injury 28b. Ti	me of 28c. I	26. Place of Deat Other: 4 Nursing Ho njury at Work? 1 Yes 2 No	me 5 Reside	e) nnce 6 Other (Spe ow injury occurred	ecify)
itel or Atte irs after des rel Director led in by the	Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, fare building, etc. (Specify)			City or Town		
To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Exeminer: On	To the best of my knowledge, the basis of examination and it manner stated.	Vor investigation, in r	ny opinion, death occur eense number	red at the time, da	ate and place, and du	e to the cause(s) th, Day, Year)
511		30. Name and address of person who complete		Type, Print)	15807		1/5/04	
Sta Registr	100	22 5 GREENE S 31. Date filed (Month, Day, Year) 1AN 2 7 2004	32. Registrar's Signature	Truce E, M	7D 2120	7/		

2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Yeer **Physician** Rehana Syed 10:41 AM 2004 January 25 /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospita 5 Social Security Number 043-54-4348 043-54-0318 Baltimore City Bultimore 6. Sex tf Under 1 Year Months Days Date of Birth (Month, Day, Yeer) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Hours Min. 1 M 2 XF Director 0 194 Usual Residence of Decedent with the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 shov other traumatic avant, the Martical Experies must be nixtified at 1 ☐ Yes 2 ₺No Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 212 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify INdian Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Anmed their Known 2 19a. Info ant's Name/Relationship (Type, Print)
Shahid A. Syed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of h Important: If Its Jan Pages 1 Durial 2 Cremation 3 Removal from State * 4 ☐ Donation S ☐ Other (Specify) injury 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility Vans Funeral eny ir Darking HURKURA RA 23a, Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tanock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PSIS /Medical Due to (or as a consequence of): Examiner Distress Syndrome Res pirator Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Disease 2 X NO 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an postati mic certificate has autopsy performed? (es 2 No Crastrointestinal 1 Yes 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No After this 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide TSC critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES mo 25 January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neva Oulikan w Sinu Hosp 31. Date filed (Month, DAM) 2 7 200 /32. Registrar's Signature Sinu Hospita Bultimon State مر المرابع Registrar

State of Maryland / Department of Health and Mental Hygiene

			S	State of I	Marylar	nd / Depa <i>Cer</i>			lealth Death			Reg.	CUL]4	0	899
61		1. Decedent's Name (First, Middle,	Last)								2. Dete of Month	Death	Dey	Yeer	3. Tim	ne of Death
Physicia /Medica		Louise Springbo	rn								Janua	ry 2	24, 20		7:	15 pm
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		Friends Nursing	Home					5	Sandy	Spr	ing		Montg	gomer	У	
Funeral		5. Social Security Number	6. Sex		Age (In yrs.	lest birthday)		r 1 Year Days	If Unde	r 24 Hrs. Min.	8. Date of (Month,	Birth	207	9. Birthp	lace (St	ate or Foreign
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filed within 72 hours after death with the Maryland Hollyeine. Whylene "natural", or frems 23a or 28a-f show ther than "natural", or frems 23a or 28a-f show ont, the Medical Examiner must be notified at		Usual Residence of Decedent									1=====					
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E	ğ	Maryland Montgo	merv		San	dy Spri	ino								1 🗆	Yes 2X No
"natural", or items 23a or 28a-f show edical Examiner must be notified at	Director	10e. Street and Number	merj		Dan	uj bpii	10f. Zip	Code				10g.	Citizen of \	Whet Cour	itry?	
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	þ	3 □XWidowed 4 □ Divorced		If Yes, Give Year or Date		1	☐ Yas	2[XNo	Specify	<i>:</i> :			Specify	White	2	
	귳	15. Decedent's	e Educati			16e. Deced	lant's Heur	al Occur	ation			168	o. Kind of B			
	Completed	(Specify only highest	grede co	mpleted)		(Give	kind of wo	rk done	during mo	st of work	king	1	5. Tune 0. D.	00111000	,	
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	၉	Charles Seiler									e Hug					
	1	19a. Informant's Name/Relationsh		,			_				rel Route Nur					7
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		20a. Method of Disposition	. D.			Place of Dispos cemetery, cren	sition (Nar natory or o	me of other plac	ce)		Januar	y 200	c. Location -	City or To	wn, Stat	e
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À	1	1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery, crematory or other place) West Arundel Crematory 27,2004 Od												. D	- 70	,
once.		Going Home Cremation Service P.														
	\rightarrow	Bevery .	NE	ywo -	MO1									VILLE		
		23a. Pert1. Enter the disease, or c shock, or heart failure. List of	omplicati nly one c	ons that cau ause on eac	sed the deat h line.	n. Do not ente	er the mod	ae or ayır	ng, such as	cardiac	or respiretory	arrest,		1	Approx Interval	mate Between and Death
n														1	Onser	and Death
1		Immediate Cause (Final disease or condition	9	Acute	Coron	ary Ins	suffi	cenc	y					13	30 m	inutes
er		resulting in death)				or as a conseq								1		
	Je l			Conges	tive	Heart I	ailu	re						ř	3 w	eeks
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	0	examiner? 1 ☐ Yes 2 ☐ No	Hosp	oital:	atient 2	ER/Outpatient	t 3□ DC	Oth	ier: 4X N	ursing Ho	ome 5□Re	sidence	e 6 □Oth	er (Specifi	y)	
	۲	27. Manner of Death	2	28a. Dete of I	njury	28b. Time of	2	28c. Injur Wor	y at		28d. Describ	e how i	injury occur	red		
	ᅙ	1 Naturel 5 Pending 2 Accident investiga		(Month,	Dey Year)	Injury	м		Yes 2□	No						
	Certification:	3 ☐ Suicide 6 ☐ Could no	ot be	28e. Place of	Injury - At h	ome, farm, stre	et, factor	v. offica			28f. Location	(Stree	t and Numb	er or Rura	I Route	Number,
	탏	4 Homicide	160	building,	etc. (Specil	(y)					City or	Town, S	tete)			
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		one)		and manner	stated.		200	Licene	o number			204	Data signa	d (Month	Dov. Vo	or)
•		29b. Signature and title of certifier	1	•			290	. LICHTIS	e number			∠90.	Date signe	a (IVIONIN, I	Joy, TO	· /
		Devet M	on	yen i	u)		D	4768	32			Jan	uary	26, 2	2004	
		30. Name end address of person w	no compl	leted cause of	f deeth (Iter	n 23e) (Type, f	Print)									
		Bennett Morrison	M.D	. 2901	01ne	y-Sandy	spr	ing	Road	01ne	ey, Man	cy1a	nd 20	832		
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			•	tificate of	nealth and h Death	Reg.	4004	0 300
	1. Decedent's Name (First, Middle, La	ist)				2. Dete of Deeth	Dey Yea	3. Time of Death
Physician /Medical	William King Smi	th					25, 2004	
Examiner	4a Fecility Neme (If not institution, given	ve street end number)			4b. City, Town, or L	ocation of Deeth	4c. County of De	eeth
	Morningside Hous	e			Ellicott_		loward	
Funeral		Sex 7. Age (li NOM 2□ F	n yrs. lest birthday)	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	er) 9. E	Birthplace (State or Foreign Country)
Director	168-03-4068	MUM ZUF	88 Yrs.			Aug. 27,	1915 Ke	ntucky
D .	Usuel Residence of Decedent 10a. Stete 10b. County	10	Oc. City, Town or Loc	cation				10d. Inside City Limits
aryle eho	Maryland Howard		Ellicott (1 ☐ Yes 2 ☒ No
Pecto Per M	10e. Street end Number			10f. Zip Code		100	Citizen of Whet	Country?
Of Portin		D .						ood.n.y.
Sites death with the Mainten as 28 or 28s-1 enter must be notified from Funeral Director	5330 Dorsey Hall		rin IJ S 13 V	21042	tispenic Origin? (Sc	USA pecify Yes or No-		merican Indian,
Tun Rem	1 Never Married 2 Married	12. Was Decedent Eve Armed Forces?	if if	Yes, specify Cub	lispenic Origin? (Sp en, Mexican, Puerto	Rican, etc.)	Black, W	
ns af	3√2 Widowed 4 □ Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:	1	☐ Yes 2X No	Specify:		Specify:	ite
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland lith and Mantal Hygiene. 17 is marked other than "natural", or items 23a or 28a-1 show traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	15. Decedent's E	ducation	16e. Deced	ent's Usual Occup	petion	. 16b	. Kind of Busine	
Pier Pier	(Specify only highest green Elementery/Secondary (0-12)	ede completed) College (1-4or 5+)	(Give I	kind of work done OO NOT use retire	during most of world)	King		
Signal Andread	Libitioniary/Goodinary (o 12)	2	Comput	ter Syste	em Develo	per Co	mputer	Technology
of Hy	17. Father's Name (First, Middle, Last)	_		18. Mother's Nam	ne (First, Middle, Maid	len Surname)	
Vlar Wanta M	Arthur H. Smith				Irene Ga	rrity		
Shot shot	19a. Informant's Name/Relationship	Type, Print)	19b. Mailin	g Address (Street	and Number or Ru	rel Route Number, Cit	ty or Town, State	e, Zip Code)
Mg alth e 27 is yr tra	Gary R. Smith/son		11821	Chapel 1	Woods Cou	rt Clarksv	ville, M	D 21029
of He and the state of the stat	20a. Method of Disposition		20b. Place of Dispos cemetery, crem	sition (Name of natory or other pla	се) .]]	anuary 20c.	Location - City	or Town, State
Page Jent c	1 ☐ Burial 2x ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	THemoval from State	Vest Aruno			6, 2004 0	lenton,	Maryland
Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed withir Department of Health end Mantal Hygiene. Important: If flem 27 is marked other than any injury or other traumatic event, tra. M once. To Be Compi	21. Signature of Funeral Service Lice					n Service		
D Pem Pem Pem Pem Pem Pem Pem Pem Pem Pem	Bour D. P	11 the						
	23a. Pert1. Enter the disease, or com shock, or heart failure. List only	polications that caused the	death. Do not ente	or the mode of dvir	necklott ng. such as cardiac	or respiratory errest.	arksvii	1e, MD 21029
Physician	shock, or heart failure. List only	one cause on each line.						Interval Between Onset and Death
/Medical	Immediate Cause (Final	Rina	ara Ca	المرماء	Δ.			Monters
Examiner	disease or condition resulting in death)	BLAD DUE	oto for on a consecu	uonce of):	1			Months
<u>ब</u> ्		REMA	tallie	e				Months
vision of Vital Records, P.O. Box 68760, attending Physician: The lew requires that the death certificate be executed an effort. After this cartificate has been signed by the ettending physician and by the funeral director, pege 2 should be datached for use as the burial-transit iffication: To Be Completed by Physician/Medical Examiner	Sequentially list conditions	D	e to (or as e consequ					
O, exec an an rial-tr	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			,				1
68760, ificata be exe g physician as the burial-ledical Ex	that initiated events	C. Due	to (or as a consequ	uenca of):				
68 tifica ng ph as th	resulting in deeth) Last							1
Box eath cert ettendin for usa	•	d						
deat deat deat se ett	Part II. Other significant conditions	contributing to death but n	ot resulting in the un	derlying cause giv	ven in Part I.	23b. Did tobac	co use contrib	ute to the cause of death?
or the state by th						1 🗆 Yes	2 ⊠ No 3□	Probably 4 - Unknown
al Records, P.O. Box: The lew requires that the death cercate has been signed by the ettendir, pege 2 should be datached for usa Completed by Physician/A			-					
ould build						24a. Was an au performed		b. Were autopsy findings available prior to
ew re la be 2 sh								completion of cause of death?
The transfer and the page of t						1 □ Yas	2 X No	1 ☐ Yes 2 ☐ No
Division of Vital Records, P.O. or Attending Physician: The lew requires that the deflar death. Director: After this cartificate has been signed by the Jin by the funeral director, pege 2 should be datached ertification: To Be Completed by Physician process.	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one)		
Of V Physici this ca ral dirac	1 ☐ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpetien	t 3□ DOA Oth	ner: 4 Nursing H	ome 5 🗆 Residence	6 Other (S	pec Assisted
On O	27. Menner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Dey Ye	28b. Time of Injury	28c. Inju	y at rk?	28d. Describe how in	njury occurred	· ·
satic	2 ☐ Accident investigation	n		M 1 🗆	Yes 2 ☐ No			
IVIS rected rected	3 ☐ Suicide 6 ☐ Could not be determined		 At home, ferm, stre Specify) 	et, factory, office		28f. Location (Street City or Town, St	t and Number or tate)	Rural Route Number,
Division of Vital Re to the Hospital or Attending Physician: The lawithin 24 hours efter death. To the Funeral Director: After this cartificate ha completely filled in by the funeral director, pege Medical Certification: To Be Com								
t hour uner uner uner uner uner uner uner un	29a. Certifier 1 Certifying Pl (Check only 2 Medical Exa	nysician: To the best of m miper: On the basis of exa	y knowledge, death amination end/or inv	occurred et the tip estigation, in my o	me, date and place, ppinion, death occur	and due to the cause red at the time, date	e(s) and manner and place, and c	es stated. lue to the cause(s)
thin 24 thin 24 thin 24 the F	one)	and menner stated		200 Line	o number	20-	Date siened #1	onth Day Voorl
vitl COI	29b. Signature end title of certifier			D T	2 % (]	290.	vale signed (Mi	onus, Doy, Todij
. *				DE	-000	Jan	uary 26	2004
111	30 Neme end address of person who	completed cause of deeth	n (Item 23e) (Type, I	Print)	- h-	1 21	111	
10	1	10.00	5-2 .10	257	The MATE	that The	(duno	is, No City
State	29b. Signature end title of certifications of the signature and title of certifications. 30. Name end address of person who are signature.	Le une,	Signature	2552.	11 W 1474 8	er Fr	Colino	A, MOZIUGE

		State	of Maryland	•	nent of He		d Mental Hygi	ene g. No. 200	4 01901
		1. Decedent's Name (First, Middle, Last)					2. Date of Deeth	1	3. Time of Death
	Physician	Hina Shah					Jan har	Dey 37 Year	V4 2:15A
	/Medical Examiner	4e Fecility Neme (If not institution, give street end	number)		41:	. City, Town,	or Location of Deeth	4c. County of De	eath
		North Arundel Hespital			G	Per 34	urnie	Horel	trundel
	Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last	Mo	Inder 1 Year onths Days	Hours M	lin. 8. Date of Birth (Month, Dey,	Yeer) 9. E	Birthplace (State or Foreign Country)
	Director	149-72-6321	34	Yrs.			Feb. 3,	1969	India
	and *	Usuel Residence of Decedent 10a. State 10b. County	10c. City, T	own or Location	n				10d. Inside City Limits
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	ath with the Marylar 23a or 28a-f show Mat be notified at rai Director	10e. Street end Number		10	of. Zip Code		10	g. Citizen of What	Country?
	3a o	2757 Summers Ridge Dri	ive		2111	3		United	States
	ifter death viriteme 234 inher must	11 Marital Status 12. Was D	ecedent Ever in U,S. Forces?	13. Was I			(Specify Yes or No- lerto Rican, etc.)	14. Race - Ai Black, W	merican Indian,
0	or he	1 Never Married 27 Married 1 Ye	s 2 D No		_	Specify:	, , , , , , ,		sian Indian
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5	ad within 72 hours ygiana. ner than "netural", nt, the Medical Ew Completed by	15. Decedent's Education (Specify only highest grade complete		6a. Decedent's	Usual Occupa of work done di OT use retired)	iring most of i	working	6b. Kind of Busines	ss/industry
12	within ana.	Elementery/Secondary (0-12) College	e (1-4or 5+)		obiolog	idat		Medio	ra1
9		17. Fether's Name (First, Middle, Last)	F	MICI			Name (First, Middle, M		
Maryland	Mantal H Mantal H arked ott attc ever	Subodhchandra Jayanti	lal Shah			Nirma	la Pursh	ottam	Shah
ary	shoul ind Mark umark	19a. Informant's Name/Reletionship (Type, Print)		19b. Mailing Ad	drass (Street a	nd Number or	Rural Route Number,		e, Zip Code)
	alth e	Jayesh Shah/ Husband		2757 Su	mmers F	didge D	rive Oden	ton, Mar	yland 21113
Ore	of Heall	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro	com	e of Disposition etery, cremator	(Name of y or other place)	Date 2	Oc. Location - City	or Town, State
Ĕ	Peg ant: h	4 Donation 5 Other (Specify)		Arunde	1 Crema	tory	1/25/04	Odenton,	Maryland
Baltimore,	Daperti Mporti Iny Inj DRCE.	21. Signeture of Funeral Service Licensee			ne and Address		Home & Cr	ematory.	P. A.
ш	2022	Juanta R Homas	M00957	1411	Annanc	lis Ro	ad Odent	on, Mary	
	,et	23a. Part . Enter the disease, or complications the shock or heert failure. List only one cause of	at caused the death. In each line.	Do not enter the	mode of dying	, such es card	diac or respiratory arre	st,	Approximate Interval Between
	Physician		C. 0	0000					Onset and Death
2.	/Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death)	> ~	187					1
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	executad in and ial-trensit Examines	b	S Puo to (or or	a consequence	21/27	٧_	9/2 11/	1 6 8 7 m	1
Ć,	t ba executad sician and t burial-trensit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequenc	e orj.				1
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O. E.	tha et nad fo	Part II. Other significant conditions contributing to	death but not resulting	ng in the underly	ying cause give	n in Part I.	23b. Did tot	acco use contrib	ute to the cause of death?
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ds,	signe d be d						24a. Wes an	autonsy 24	b. Were autopsy findings
Ö	baan shoul						perform		available prior to completion of cause of death?
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<u>=</u>	. = 0	examiner?	Minpatient 2□ER	/Outpatient 3	DOA Othe		g Home 5 ☐ Resider		(pecify)
ō	£ £ = '	27. Manner of Death 28e. Da	/-	b. Time of Injury	28c. Injury Work		28d. Describe ho		,
<u>Ö</u>	Attending Phyrideath. octor: After the by the funeral	2 Accident investigation	ional, buy rour,	N		es 2□No			
Division of Vital Records,	tal or Attending P rs after daath. al Director: Aftar t lad in by the funara Certification:	3 Suicide 6 Could not be determined 28e. Place but the suicide 28e.	ece of Injury - At home ilding, etc. (Specify)	e, farm, street, f	actory, office		28f. Location (Str. City or Town,		Rural Route Number,
	ital or its after all Dir. Italiad in Cert								
7	To the Hospital or At within 24 hours after of To the Funeral Direct complately filled in by Medical Certiff	29a. Certifier (Check only (Ch	basis of examination	dge, death occi and/or investig	urred at the time pation, in my op	e, date and pla inion, death o	ace, and due to the ca ccurred at the time, da	use(s) and manner te and place, and c	as stated. due to the cause(s)
4	To the Vithin 2 To the Complain	29b. Signature and title of centifier	anner stated.		29c. License	number	29	d. Date signed (Mo	onth, Day, Yeer)
	2 ± 2 € 5 €	1	MD		1)49	3006	5	Carrier	y 23, 2004
_	h	30. Name end address of person who completed c	En!	301	Hosp	11-	Dr.) 6	ylan Bi	Janst, mD
	State		. Registrer's Signature	South	61				
	Registrar	JAN 2 7 2004 Den	/ /-	The same					

DHMH 16 Rev 6/9

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 📗 🕒 😓 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death January 21, **Physician** 2004 2:00 p M Lettie Virginia Sheeler /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year Months Days If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Hours Min. 1□M 2√F 219-16-6548 87 Dec. 3 1916 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2X No by Funeral Director MDBaltimore Sparks 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1J Shelby's Path **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ **X**0 Specify: Specify: white 3€ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 n/a Valley View Farms manager permit. Pages 1 and 2 should be lited v Department of Health and Mental Hygie Important: If item 27 is marked other t eny injury or other traumatic event. In once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Robert Chaffman Annie Turnbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Sheeler/daughter 1 J Shelby's Path, Sparks, MD 21152 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Jessops Church Cem. 1/24/04 Sparks, MD 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W Padonia Rd., Timonium, MD 21093
Approximate 21. Signature of Funeral Service Licenses Bryan W. Clai 10 W. Padonia Rd., aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ach line. 23a. Part1. Enter the dis-shock, or heart fail ase, or complications that caus re. List only one cause on a ch Approximate Interval Between Onset and Death Indir pulniman disease Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of the year) that initiated events Due to (or as a consequence of): Completed by Physiclan/Medical Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ŏ 4 Pregnant at time of death 5 Other (specify) detached P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 2 No 3 Probably 4 Unknown Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 Appatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No ۵ 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred Medical Certification: Division 5 Pendina 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital o within 24 hours aff To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29d. Date signed (Month, Day, Year) 29b. Signa who completed cause of death (Item 23a) (Type, Print) 6701 N HARLES 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗍 🗓 🗓 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 415 **Physician** 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Catonsville Baltimore Catonsville Commons | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | FEB 2, 192 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛱 F 81 217-22-1417 Yrs Georgia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10b. County 10a. State or 28a-f show nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla artment of Health and Mental Hygiene. Portant: If flem 27 Is marked other than "naturel", or litems 23e or 28e-f show injury or other traumatic event, If a Marical Examiner must be notified at injury or other traumatic event, If a Marical Examiner must be notified at 1 ☐ Yes 2 No N/A Baltimore Maryland Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21229 4800 Frederick Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. e filed within 72 hours after all Hygiene.

other than "naturel; or itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: **Black** Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ida Davis Alex Andrews 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4800 Frederick Avenue Baltimore, MD Rudolph Turner/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 1-26-04 Baltimore, MD *4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Cremation Society of 299 Frederick Road MDEdward A. Gregorchik Baltimore, 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physiclan/MedIcal IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☒ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown s peen si should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an cate has l page 2 s autopsy 1 ☐ Yes 2 1 No this certificate To the Hospitel or Attending Physicien: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ို 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar DULHJU

Year)

31. Date filed (Month, Day)

32 Registrar's Signature

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-11	E		Decedent's Name (First, Middle								Date of De Month	uath Day	Year	3. Time of Death
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	xamin	er	ta. Fecility Name (If por institutio	n, give st	treet and number)			4b. City, Town,		of Death			ounty of Deatl	_
7			7601 Plumbers 5. Social Security Number	6. Sex			last birthday)	SeVe		24 Hrs.	8. Date of Bir	th	9. Birth	hplace (State or Foreign
n Fe	ineral rector		215-64-4878 Usuel Residence of Decedent		M 2□F	46	Yrs.	Months Days	Hours	Min.	JAN 30	0, 195	Co	yland
5	-f show	tor	10a. State 10b. County Maryland Anne		ndel		y, Town or Lo 7ern	cation						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
with the	3a or 28a If be noti	Funeral Director	10e. Street and Number 7601 Plummers	Pas	ture Lan	e		10f. Zip Code 21144				10g. Citize	en of What Co	untry?
death	THE S	Jera	11. Marital Status	1	2. Was Decedent Armed Forces	Ever in U.	S. 13.	Was Decedent of	Hispanic Ori	igin? (Spe	cify Yes or No	o- 14	I. Race - Ame Black, White	
036 urs after	0 1	þ	1 Never Married 2 Mar 3 Widowed 4 Divorce		1 Yes 2 Yes Year or Dates:			1 ☐ Yes 2 X No			nouti, oto.,	S	pecify:	White
5-0	"natural"	eted	15. Deceder (Specify only higher				16a. Dece (Give	dent's Usual Occi kind of work don DO NOT use retir	upation e during mos	st of workin	ng	16b. Kind	d of Business/	Industry
2121 ad within giene.		Completed	Elementary/Secondary (0-12)		College (1-4or	5+)	I	Mechani	С					e Repair
Maryland 21215-0036 and 2 should be filed within 72 hours all lith and Mental Hygiene.	irked oth	To Be (17. Father's Name (First, Middle Victor Everet		inchcomb	, Jr.			Sara	a Anne	(First, Middle e Smitl	n		71777
and I	aum a		19a. Informant's Name/Relation					ng Address (Stree						_
	Item 27 other tr		Sara A. Stinch	comb	/Mother	20h F		B & A B	outeva		Arnolo		21012 ation - City or	
More	or other		20a. Method of Disposition 1 □ Burial 2 ▼Cremation		emoval from State	9	emetery, cre	matory or other pi	_ '					
Baltimore, bermit. Peges 1 ar	rtant njury		*4 ☐ Donation *5 ☐ Other (Met		ematory 2. Name and Add	(C iii	1-26		balt	timore,	, ш
Balti permit. Depertin	Important: If Ite eny Injury or of once.		Edward A 23a. Pent1. Enter the disease, c shock, or heart failure. Lis	. <i>L(4</i> Gr	egorchik	u		Crematio 299 Fred	n Soci erick	Lety Road		Inc.	e, MD	21228 Approximate
/Mc	sician edical miner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	f b	Due to (or as	ion s a conseq s a conseq	uence of):						1	
68760	sicien e burial				l									
Box eath cert	signed by the attending physicien I be detached for use as the buria	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2	3c. If yes, outcom 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 🗆 Feta	ildeath 3	□Ectopic pregnar □ Other (specify)				23	3d. Date of del Month	livery Day Year
P.O.	ad by detacl		Part II. Other significant condi	tions con	tributing to death	but not res	sulting in the	anderlying cause	given in Part	l.	23e. Did	tobacco use	e contribute tr	o the cause of death?
ds,	signe d be	Completed by	Atherosclerotic C								1 🗆	Yes 2	No 3 P	robably 4 Unknown
Vrequ	been s should	ete	Status Post Crani	otomy							24a. Wa	s an	24b. Were at	utopsy findings available
Rec. The law	ge 2	dmo	beaters rest carain	occas,							/ perl	opsy ormed?	prior to death? 1 1/2 Yes	completion of cause of
tal	certificate has rector, page 2	ပိ	25. Was case referred to medic	al					26. Plac	e of Death	1 X Yes	2 ☐ No one)	7103	2010
of Vita Physician:	s cert	OB	examiner? 1 ☑ Yes 2 ☐ No		fospital:	tient 2	ER/Outpatie	nt 3 DOA)ther				☐Other (Spe	ocify) at scene
On ding	or: After this certificate has he funeral director, page 2	Certification: T	ZLANCCIONIL	tigation	28a. Date of In (Month, D	104	28b. Time Injury 270	5 M 1	☐ Yes 2	46	28d. Describe	WAL	LOJSK F	SUBSECT
Divis Hospitel or Att	To the Funeral Director: completely filled in by the		4 Homicide deter	mined	building,	etc. (Speci	MAT	reet, factory, office	/		City or To	own. State)	AWKS,	EUG. 2 NJ MS
e Hospl	e Funei letely fill	edical	29a. Certifier 1 Certify (Check only one) 2 Medica	ing Phys al Exemi	sician: To the bes ner: On the basis and manner	of an in	owledge, dea ation and/or i	th occurred at the nvestigation, in m	time, date a y opinion, de	nd place, and place, a	and due to the ed at the time	e cause(s) a , date and p	ind manner as place, and due	s stated. e to the cause(s)
To the	Comp	Me	29b. Signature and title of certif		14	\.\r\ _\.\r	3	1	ense number CME				signed (Mont ary 25	th, Day, Year) 2004
5	16		MANYO	1. (mpleted cause of	M		Print) 111	Penn s	stree	t, Bal	timore	e, Mar	yland 21201
2216	Sta Regist		31. Date filed (Month, Day Yea	(r)	32. Régis	strar's Son	arure April	all						

		1	For State Registrar	State of Ma	ryland			of Hea of De			Re	ene () ()		1905
	Physicia	an	1. Decedent's Name (First, Middle, Last)				SHIMO	CC			Date of Death Month	Day Ye	ear	3. Time of Death
	/Medic	al	ELIOT 4a. Facility Name (If not institution, give s	treet and number)				Town, or Loc	ation of I		1711-5	4c. County of I	1	Dra
	Examin	er	LEVINDALE HEBREW				177	TIMORE						N/A
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. k	ast birthday)	If Under Months	1 Year If t		Hrs. 8. D Min. (/	ate of Birth Month, Day,	Year) 9.	. Birthplac	
	Director		054-30-6343 A	M 2□F	61	Yrs.				J <i>F</i>	N.24,	1943		VA
	and w	1	Usuel Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d	. Inside City Limits
	Mary	tor	MD N/A	İ		BALT	IMORE							1 Yes 2 No
	uth with the Marylar 23a or 28a-f ehow ust be rudified at	Director	10e. Street and Number				10f. Zip			_	10	g. Citizen of Wha		
	deeth with the Maryland ms 23a or 28a-f ehow r must be rudiffed at	rail	5800 STUART AVENU	L 12. Was Decedent B	vor in III	6 13 1	Nas Dacad		2121		Yes or No-	14. Race -		.S.A.
_	or items	Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Armed Forces?				ent of Hispar of Cuban, M		Puerto Ricar	n, etc.)	Black,	White, etc	э.
2	hours al tural', or al Eram	ρ	3 Widowed 4 Divorced	1 ☐ Yes 2 📉 N If Yes, Give X Year or Dates:			1□Yes 2	X No Si	pecity:		-	Specify:	W	HITE
ე ი	72 hours "netural", idical Erra	etec	15. Decedent's Educ (Specify only highest grade	cation completed)		(Give	lent's Usua kind of wor DO NOT us	d Occupation	n ng most c	of working	1	6b. Kind of Busin	iess/Indus	stry
7	within 72 ene. than "ne!	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)				OR -	PSYC	HOLOGY	EDU	JCATI	ON
2	be filed within 72 hours after deeth with the Maryla tal Hygiens at all al Hygiens of d other than "neturef", or thams 23s or 28s-1 should deet than "neturef", or thams 23s or 28s-1 should be event, it as Medical Examinar must be reditted at	0	17. Father's Name (First, Middle, Last)					18.			st, Middle, M	aiden Sumame)		
yland		To B	EPHRAIM		S	HIMOFF				RLEY				ANN
Jau	C & - 6		19a. Informant's Name/Relationship (Ty)	pe, Print) WIFE			-					City or Town, Sta E, MD 21		ode)
a)	s 1 and f Heelth item 27 other t		20a, Method of Disposition		20b. P	lace of Dispo	sition (Nan	ne of	LNOL	Date		Oc. Location - Cit		n, Stete
ē E	0 = 5		1 ☐ Burial 2 ☐ Cremation 3 🕍 R 1 ☐ Donation (5 ☐ Other (Specify)	emoval from State	1	emetery, cren TZ CHA			Y 1	/25/20	004	BEIT SHE	MESH	, ISRAEL
Baitimore,	mit. Par partmen portant: y injury ce.		21. Signature of Funaral Service License	90		22	. Name an	d Address of	f Facility	SOL I	EVINS	ON & BRC)S.,	INC.
מ	8258		GOOD THAT									IKESVILL		D 21208
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused ne cause on each lin	the death		Org.	1 . 1		Jac or res		n	l Ir	onterval Between
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	uence of):				7				•
H		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	uence of):			U					
	ate be executed hysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequ	uence of):								
760,	be ex sicien burial	calE		1										
9	tificate ng phys as the	_												
Box	es jā	an/M	23b. Was decedent pregnant	3c. If yes, outcome 1☐Live birth	2 Feta	Ideath 3	∃Ectopic pr					23d. Date of Month		ay Year
O.	Q 0 Q	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of de	eath 5	Other (sp	ecify)						,
۵.	The law requires that the ste has been signed by th bage 2 should be detache	/ Ph	Part II. Other significant conditions cor	ntributing to death b	ut not res	ulting in the u	nderlying o	ause given ir	n Part I.		23e. Did tob	acco use contribu	ute to the	cause of death?
rds	w requires l been signs should be	ed by	Metastatic,	msta-	te C	ance	V				1 🗍 Ye	s 2□No 3	☐ Probab	by 4 Honknown
Records,	e law rec has bee ge 2 sho	Completed	/								24a. Was an	24b. We	re autops	y findings available pletion of cause of
		Com									perform 1 ☐ Yes 2	No 1	ath?]Yes 2	□ No
Vita	ysician: The l is certificate ha director, page	Be	25. Was case referred to medical examiner?	fospital:		500		Other			neck only one		(Canality)	
	Attending Physician: ir death. ector: After this certification in the funeral director,	1: To	1 Yes 2 No	28a. Date of Inju	ry	ER/Outpatier 28b. Time o		28c. Injury at Work?				nce 6 Other w injury occurred		
O U	ath. r: After	ation	1 □ Natural 5 □ Pending 2 □ Accident investigation	(Month, Da	y rear)	Injury	М		2 🗆 N	lo				
Division of	or Atte after de Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At ho c. <i>(Specif</i>	ome, farm, st	reet, factor	y, office		28f.	Location (Str City or Town	eet and Number , State)	or Rural I	Route Number,
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medical Exami	sicien: To the best	of my kno	wledge, deat	h occurred	at the time,	date and	place, and	due to the ca	use(s) and mann	ner as stat	ed.
	the H in 24 the Fi	Medical	one)	and manner st		MON AND ON		c. License nu				d. Date signed (
	Viit To CO	~	29b. Signature and title of certifier	No	>		29) 4 (13-				
,	3	1	30. Name and address of person who ca	ompleted cause of c	leath (Iten	n 23a) (Type.	Print)	- (, - 1		-	s An-	0.	
_			Sunt le	jem'	C	3431	f hi	Kel	vee	lere	au	e 184	Mi	More
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ature	Ann	Kal				7	~	447
			2 2 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	William D. Co. T. Mark		10	والأسما الماتوجمام	100						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** January ŽŽ, 2004 Α. Joseph Sliakis 5:10 pm /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner Cromwell Center Baltimore Genesis Towson if Under 24 Hrs. 7. Age (In yrs. lest birthdey) If Under 1 Year 8. Date of Birth (Month, Dey, Year August 8, 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours Min 1√2 M 2□ F Maryland Yrs. 1909 094-03-7745 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "naturel", or items 23e or 28e-f show the Medical Examiner, must be notified at 1 ☐ Yes 2 No Director Towson Baltimore Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21286 USA 205 East Joppa Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian. Black, White, etc. pemit. Pagas 1 end 2 should be filad within 72 hours efter Dapertment of Hauth and Mantal Hyglana. Important: if item 27 ia marked other than "naturel, or ite important or other than the Mantal Pagantant event, the Modical Examinary injury or other thaumatic event, the Modical Examina 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: ğ 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondery (0-12) College (1-4or 5+) United State Postal Service Postal Service 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Sliakis Anna Remeikis Adam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Anna Monfredo / Sister 205 E. Joppa Road Towson, Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ⊭illtop Service Corp. 1/26/04 Towson, Md. 21. Signature Funeral across Line 22. Name and Address of Facility 1050 York Road Towson, Md.21204 Ruck Towson Funeral Home, Inc. tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the diseese shock, or heart failure. **Physician** ence Dementin Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as e consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires thet the death certificete be executed Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ρ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 🕍 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No 3 DOA 28c. Injury at Work? 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Naturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident oftar daath. investigetion Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours of To the Funersi C complately filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 2 29b. Signature and title of certifier 29c. License number

Registrar

State

Will RAVEA

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

2004

31. Date filed (Month, Day, Year)

5601

32 Registrer's Signatur

	_	State of Marylan			. Ensure All lealth and M	_		_	0100
	1 - For State Registrar	Otato of Marytan		tificate of		icinai i iy	Reg. No.	ZUUL	1 1 1 9 1
	1. Decedent's Name (First, Middle,	Last)				2. Date of De _ Month	-	Year	3. Time of Death
an cal	Lauren	Patricia	Sn	yder		Januar	у 17,	2004	2050P M
er	4e. Fecility Name (If not institution,			4b. City, Town, o	r Location of Death		4c. (County of Dea	th
	6949 Ten Timber			Pikesvi			E	Baltimo	re
	213-68-4569	7. Age (In yrs. 1 ☐ M 2 ☐ XF 37	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bit (Month, Da NOV 15	iv. Year)	C	thplace (State or Foreign puntry) aryland
	Usuel Residence of Decedent 10a. State 10b. County	10c C	ity, Town or Lo	cation					10d. Inside City Limits
5									1 Yes 2 No
Directo	Maryland Baltim 10e. Street and Number	ore	Mt. W	lashingto	<u>n</u>		10 011		
				10f. Zip Code				en of What C	ountry?
Funeral	6949 Ten Timber		16 140.11	212		7 M		.S.A.	-2
Ę	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto	Rican, etc.))-	 Race - Ame Black, White 	
by	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 🗖 No If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:		3	Specify:	White
ted	15. Decedent's			lent's Usual Occup			16b. Kin	d of Business	
pie	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done of NOT use retired	during most of work d)	ing			•
Completed		4	l	egal Spe	ecialist		L	aw	
To Be C	17. Father's Name (First, Middle, La	est)			18. Mother's Name	(First, Middle	, Maiden S	iumame)	
	James P	. Kosker			Gerald	ine	M. [)obrzyk	owski
	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	g Address (Street a	and Number or Rura	i Route Numb	er, City or	Town, State,	Zip Code) 21209
	Bruce A. Snyder	Husband	6949	Ten Timbe	ers Lane	Mt. Wa	shing	ton. N	lary land
	20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3		Place of Dispos cemetery, crem	sition (Name of natory or other place	:e)	Date	20c. Loc	ation - City or	Town, State
	*4 □Donation 5 □ Other (Sp		lltop S	ervice Co	orp. 1-21	-2004	Tov	vson	Maryland
	21. Signature of Funeral Service Li	ense							Home, Inc.
11	Ceny TXX	1		050 York		owson,			21204
	23a. Part1. Enter the disease, or co	implications that caused the dear	th. Do not ente	or the mode of dyin	g, such as cardiac o	r respiratory a	rrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition		a Mi	in to 6	roughing	2			Onset and Death
	resulting in death)	Due to (or as a consec			0 8				
			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					İ	
je.	Sequentially list conditions, if any, leading to immediate cause. Liner Univerlying Cause (Disease or injury	Due to (or as a consec	uence of):						
xaminer	Cause (Disease or injury that initiated events	G							
Exa	resulting in death) Last	Due to (or as a consec	quence of):	·					
edicai		d							
fedi									
N/V	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy							d. Date of del	ivery
hysician/M	in the past 12 months?	4 Pregnant at time of c		Other (specify)				Month	Day Year
hys	9 XUnknown	9 Unknown							
Part II. Other significant conditions contributing to death but not resulting in the underlying car					use given in Part I. 23e. Did tobacco use contribute to the cause of deat				the cause of death?
eted !						101	es 2 🗷	No 3□Pr	obably 4 Unknown
Complet	24a. Was an 24b. Were auto							topsy findings available	
E						autop	rmed?	prior to death?	completion of cause of

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Funeral Director: After this certificate ha completely filled in by the funeral director, page 3 within 24 hours after death.

To the Funeral Director: A

Medical Certification; To Be Com

19

State Registrar

31. Date filed (Month, Day, Year) JAN 2 7 2004

29b. Signature and title of certifier

25. Was case referred to medical examiner?

XXYes 2 No

27. Manner of Death

1 Natural

2 Accident 3X Suicide 4 ☐ Homicide

and address of person who completed cause of death (Item 23a) (Type, Print)

ABIALL AH ALI

28a. Date of Injury (Month, Day Year)

1/17/04

111 Penn Street, Baltimore, Maryland 21201

Other: 4 Nursing Home 5 Residence 6 Dother (Specify) At SCEDE

Location (Street and Number or Rural Route Number, City or Town, State)

6944 Ten Timbers Lame, Pikesville, MD

29d. Date signed (Month, Day, Year)

January 18, 2004

28d. Describe how injury occurred

26. Place of Death (Check only one)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

1 Yes 2 No

5 Pending investigation

6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

8:20

Darelen Preston 04-00346 crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1		,	Amend Item 1 = StateUnpend Item#23a,	#State of Marylan Part II,27,PerMe,	nd / Depa G830 4/7	rtmen	it of Health e of Death	and M	lental Hyg	iene eg. No.	2004	01008
			1. Decedent's Name (First, Middle, La		ston				2. Date of Deat Month	th		3. Time of Death
	Physici /Medio		DAKLENC	SANJERD-1	Treston	J.,			January	13,	2004	7:15 P M
7	Examin		4a. Facility Name (If not institution, giv			•	Town, or Location	of Death		4c.	County of Death	
			1020 West Saratog				altimore	2111			N/A	
	Funeral Director		214 18 3/37	ex 7. Age (In yrs.	last birthday) Yrs.	If Under Months		Min.	8. Date of Birth Month, Day	Year) /96	Cou	place (State or Foreign ntry) TENSCy
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Loc	ation						10d. Inside City Limits
	f ehc	ō	Marilan N/		BAKIN	irc						Tes 2□No
	289.	rec	10e. Street and Number			10f. Zip	Code		1	0g. Citiz	en of What Cou	ntry?
	3a or	0	200 S. ARLIN	STEN AUE			21223				USA	
	death me 2	Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. W	/as Dece	dent of Hispanic O cify Cuban, Mexica	rigin? (Spe	ecity Yes or No-	1	4. Race - Amen	
9	or Ite	Ē	1 ☐ Never Married	1 Yes 287No		□ Yes			nican, etc.)		Black, White,	
93	ral.	d by	3 Widowed 4 Divorced	Year or Dates:	'		Zastito Specify	·			Specify: 73/c	icle
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Iteme 23a or 28a-f ehow the Madical Examinar must be motified at	Completed	15. Decedent's E. (Specify only highest gra		(Give k	and of wo	al Occupation ork done during mo	st of work	ing	16b. Kir	nd of Business/Ir	ndustry
121	han na	E E	Elementary/Secondary (0-12)	College (1-4or 5+)		VIER	se retired)			57	OKE	
	rould be filed within I Mental Hygiene. Sarked othar than satic event, the M		17. Father's Name (First, Middle, Last,	24 CARS	Crisi			her's Name	e (First, Middle, i	Maiden .	Sumame)	
Maryland	d be ontall	Be c	GILBERT SAM	lord					BAK			
<u>Z</u>	2 should and Men is marks aumatic	ဥ	19a. Informant's Name/Relations (Type, Print)	19b. Mailing	Address	1 - 1 - 1		I Route Number	, City or	Town, State, Zij	Code) 08302
Ma	C/ a = 6	1	Papair CARKE	MOTHER			Rlington		Anur	5	ridash	own, State
ē,	s 1 and f Health item 27 other tr		20a. Method of Disposition	20b. F	Place of Dispos	ition (Na			Date	20c. Loc	cation - City or T	own, State
E			1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specil	Hemoval from State 1/1	ENSHALIN	+ C	Bricker	1-1	19-04	alh	ner M	orylono
Baltimore	글 된 만 글 .		21. Signature of Funeral Service Lice		22.	Name a	nd Address Faci	ility CAI	MINE	-1/1	mi ty	rent Hones
Ö	Depa Impo eny i	/	Juny Ha	Pures	13	MI	NUT 16	let an	dir			
	Delling.		23a. Part. Enter the disease, or com- shock, or hant failure. List only	plications that caused the deat	th. Do not ente	r the mod	de of dying, such a	s cardiac	or respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Acquired Immun	odeficie	ncy S	yndrome(ATI	E)				Onset and Death
	/Medical		resulting in death)	Due to (or as a consec	quence of):							
	Examiner	L.	Sequentially list conditions,	b								
	Si ad	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	mence of:							
	eath certificate be executed attending physician and for use as the burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as a consec	zuence of):						_	
760,	be ey ician buria	cal E			,							
687	phys phys the			_ d								
×	death certifica e attending ph id for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregn	ancy					2	3d. Date of deliv	rerv
Вох	atter I for u	clar	23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \)	1 Live birth 2 Feta 4 Pregnant at time of c		Ectopic p Other (s)	regnancy pacify)				Month	Day Year
o.	that the death ed by the atte detached for	ysi	9 Unknown	9□ Unknown								
σ,	The law requires that the ate has been signed by th page 2 should be detache	by Pi	Part II. Dther significant conditions		sulting in the un	derlying	cause given in Part	t 1.	23e. Did to	bacco u	se contribute to t	the cause of death?
Records,	quire an sig u(d b)	be to	Chronic Renal Fail	ıre					1 🗆 Y	es 2[No 3 Pro	bably 4 Dunknown
S	s been si 2 should	plet							24a. Was a			opsy findings available ompletion of cause of
æ	The law	Completed							perfor	med? 2 X No	death? 1 ☐ Yes	2 50 No
Vital		Bec	25. Was case referred to medical examiner?				26. Plac	ce of Deat	h (Check only or	/1		
of V	Physician: this certific ral director,	To	1X Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 □ D	OA Other: 4 🗆 N	Nursing Ho	me 5 ☐ Reside	ence 6	Other (Speci	y)at scene
0 [ng Pl	i.i	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury at Work?		28d. Describe h	ow injury	occurred	
Sio	Attending r death. sctor; After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be			М	1 Yes 2	□No				
Division	or Att	Certification:	4 Homicide determined		nome, farm, stre ify)	et, factor	y, office		28f. Location (Si City or Town			al Route Number,
	pitel urs a arel [Continue A Continue B	nucleions To the best of my les	outedoo dooth		for the time, date of	and place	and due to the e	(-)		
	Hosp 24 ho Fune Holy f	edical	29a. Certifier 1 Certifying P	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death ation and/or inv	estigation	rat the time, date a n, in my opinion, de	and place, eath occuri	and due to the c red at the time, d	ause(s) late and	and manner as s place, and due t	stated. to the cause(s)
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Mec	29b. Signature and title of certifier	with the state of		29	c. License number	r	2	9d. Date	signed (Month,	Day, Year)
	ك∓ة		110	11 1/2			O.C.M.	.E.	т.	โลกบล	ary 14,	2004
			30. Name and address of person who	completed cause of eath (Ite	m 23a) (Type I	Print)	O.C.FI.			ui u	~-	200 I
			THEVOOR	M. Kary			enn Stree	et, B	altimore	, Ma	aryland	21201
	St	ate	31. Date filed (Month, Day, Year) JAN 2 6 2004	32. Registrar's Sign							-	
	Regist		JAN 2 6 2004	General	9	30.60	1					

			For	State of Mary	land / Depa	artment of H	ealth and I	Mental Hygie	ene 2001	. 11000
			State Registrar		Cei	rtificate of L	Jeath		.No	7 01711
	Dhysiai		1. Decedent's Name (First, Middle, Last)	0	_	10000	1 -	2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		BOBBY	K.	,	HOMA		JANUARY		/
?	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location of Death	1	4c. County of Deat	h
П			BON SECOURS H			BALTI			N/A	
	Funeral		5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	3. Date of Birth (Month, Day, 1	ear) 9. Birt	hplace (State or Foreign unity) 1th Carolin
	Director		213 00 1340 1	M 2□F 4	7 Yrs.			JAN.5,	957 501	ith Carolin
	p		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	nation				10d. Inside City Limits
	aryla ahov	_	MD . 10b. County	1.0	BALTIM					1X Yes 2 □ No
	Ba-f.	cto	MD. N/A		DALLIN			1	(111	
	라 다 0 2 2)ire	10e. Street and Number	OLIN DOAD		10f. Zip Code	21223	100	D.S. (-
	death with the Maryland ims 23a or 28a-f ahow rreast be natified at	by Funeral Director	330 S. FRANKLINT							
	ems	ne	TI: Maria Galas	Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S In, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
36	or h	Ϋ́	Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give		1 ☐ Yes 2 No	Specify:		Specify:	BLACK
Ö	ural'		3 Widowed 4 Divorced	Year or Dates:	16a Dece	dent's Usual Occupa	ation	16	6b. Kind of Business	Industry
21215-0036	be filed within 72 hours after death with the Marylan ital Hyglene. Id other than "natural", or flems 23a or 28a-1 ahow other than "natural", or flems 23a or 28a-1 ahow avent, the Madical Examiner court be notified at	Completed	(Specify only highest grade		(Give	kind of work done of DO NOT use retired	during most of wor	king		,
12	withly and the than	립	Elementary/Secondary (0-12)	College (1-4or 5+)					SUPER MAI	סעביתי
	Hygie ther nt.		12 TH 3	YEARS	PROD	UCE SALI		ne (First, Middle, Ma		XIXII
aŭ	fentai l	Be	BOBBY RUSSELL T	HOMAS SR	. (DECE	ASED)	ANNA	HOOKER (DECEASE	0)
Ž	hould d Men narke natic	ဥ	19a. Informant's Name/Relationship (Typ						City or Town, State, 2	
Maryland	s 1 and 2 should f Health and Men item 27 is marke other traumatic		MARY R. FORD (S			•				4D. 21223
_	1 an Heal em 2 ther		20a. Method of Disposition	2	20b. Place of Dispo	osition (Name of		Date 20	c. Location - City or	
ŏ	8° = 5		1 Burial 2 □ Cremation 3 □ Re	moval from State	MT. ZIO	N CEMETI	ËRY 1/1	7/04 LA	NSDOWNE	, MARYLAND
ţ	I. Pag ntment rtant: I njury o		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Fineral Service Lice 15	MITO III C	TAXANINI 2	2. Name and Addres	ss of Facility			
Baltimore,	permit. Pag Department Important: any injury once.		1	Hard.	L	EWIS T.	GWYNN		HOME 212	215-6393
	200		23a. Part 1. Errier the disease, or complic	ations that daysed the	death Do not en	517 PARI	K HEIGH	TS AVENU	E BALT	Approximate
			shock, or heart failure. List only one	e cause on each line.			•			Interval Between Onset and Death
1	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death)	_Sept		hock				
	Examiner			Due to (or is a co	onsequence of):	brack	Llean	lina		
		<u>-</u>	Sequentially list conditions, b.	Due to (o as a co	onsequence of):	mac	bleed	119		
	ted	ë	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Hero	10	huce				
	xecu al-tra	Examin	that initiated events c. resulting in death) Last	Due to (or as a co	onsequence of):	X IZMS C				
760	ate be executed sysician and he burial-transit	caiE								
687	ficate phys		U.							
×	eath certificate attending phy I for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of p					23d. Date of de	livery
Вох	atter atter	clar	in the past 12 months?	1□Live birth 2 [4□Pregnant at tim		□Ectopic pregnancy □ Other (specify)	<u> </u>		Month	Day Year
o.	at the de by the a tached	ıysi	9 Unknown	9□ Unknown						
Δ.	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it		Part II. Other significant conditions con-	tributing to death but n	ot resulting in the	underlying cause giv	en in Part I.	23e. Did toba	icco use contribute to	the cause of death?
of Vital Records,	uires n sigr	d by	Acute Kei	1a/ 7	ailur	e		1 ☐ Yes	2 □ No 3 □ P	robably 4 SUnknown
8	w requ	Completed						24a. Was an	24b. Were a	utopsy findings available
Re	he lav e has ige 2	Ĕ						autopsy	ed? death?	completion of cause of 2 ☐ No
a	ician: The certificate har rector, page		25. Was case referred to medical				26 Place of De	1 ☐ Yes 2 ath (Check only one		
<u>=</u>		o Be	avaminer?	ospital:	2 ER/Outpatie	nt 3 DOA Oth	00		ce 6 Other (Spe	ocify)
		7; To	27. Manner of Death	28a. Date of Injury	28b. Time		v at	28d. Describe how		
o	ding F th. : After s funera	ē	1 Alatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yo	ear) Injury		Yes 2 □ No			
Division	Attendir r death. ector: Ai	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (treet, factory, office		28f. Location (Stre City or Town,	et and Number or R	ural Route Number,
Ö	al or A safter I Direct	Certification;	4 Homicide	Dallallig, etc. (<i>эрвину</i>)			ony or round		9
	Hospital or Attending 14 hours after death. Funeral Director: Afte tely filled in by the fune		29a. Certifier 1 Certifying Phys	icien: To the best of n	ny knowledge, dea	th occurred at the tir	me, date and place	e, and due to the cau	use(s) and manner a	s stated.
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medicai	(Check only 2 Medical Exeminate one)	and manner stated						
	To the Hospital within 24 hours a To the Funeral I completely filled	Σ	29b. Signature and title of certifier	0		29c. Licens		29	d. Date signed (Mon	
			1 CMM/	eller	7		9327		1/11/00	
_	3	1	30. Name and address of person who co		th (Item 23a) (Type	, Print)	1	7	to Md	21220
				Marian	n 466	O WILKE	ers A	re ixel	10 11d	dizzy
		ate	31. Date filed (Month, Day, Year)	.32. Registrar's	Signature	books				
	Regist	rar	JANE C C CUU4:	Last .	6	1	A			

			1 - For State Registrar	State of Maryland		ent of Hea		ental Hygie	6004	01910
	Physici /Medio		1. Decedent's Name (First, Middle, Last)	roden				ACTION 1	Day Year	
14	Examin Funeral Director	_	213-01-5999	Ap+ 413			imar	8. Date of Birth (Month, Day, Ye Sept 11	9. Birth	nplace (State or Foreign on the Company)
	death with the Maryland ims 23s or 28s-t show	Director	Usual Residence of Decedent 10a. State 10b. County N		y, Town or Location	Bal	timor	<u>e</u>	Citizen of What Co	10d. Inside City Limits 1 ☑ Ves 2 ☐ No
36	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. is marked other than "natural", or items 23s or 28s-t show armatic event, it is Medical Exament must be notilised at	by Funeral Dire	10e. Street and Number 833 W. Proith 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Apt 413 12. Was Decedent Ever in U. Armed Forces? 12Yes 2 No If Yes, Give Year or Dates:	S. 13. Was De		nic Origin? (Spedexican, Puerto F		14. Race - Ame Black, White	ncen Indian,
Maryland 21215-0036	be filed within 72 hours after ital Hygiene. Id other than "natural", or lie event, the Medical Examine	Completed	15. Decedent's Edui (Specify only highest grade Elementary/Secondary (0-12)	cation	16a. Decedent's U (Give kind of life. DO NOT	work done during use retired)	ng most of working Very K	eg 161 (First, Middle, Mai	Stee	Industry
	s 1 and 2 should be fi f Health and Mental H Item 27 is marked ot other traumatic ever	To Be	John Joode 19a. Informant's Name/Relationship (Ty. Jerlene Box	Do. Print)	1951	ess (Street and	Eona Number or Rura	Route Number, C	ity or Town, State, Z	21293
Baltimore,	permit. Pages 1 and 1 Department of Health Important: It Item 27 any injury or other tr 2005.		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signatur of Fun ral Service Licens	lemoval from State	Place of Disposition (hametery, crematory) CAN 1 SON 22. Name	Fores and Address o	1-28	3-04 C	c. Location - City or Lines M redhillon Pes	Town, State M M Z1ZZ9 S BaltomD
100	Pnysician /Medical	3.00	23a. Part: Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the deather cause on each line. Due to (or as a consequence)	Panco	node of dying, s	uch as cardiac o	respiratory arrest		Approximate Interval Batween Onset and Death Onset Approximate
760,	ficate be executed physician and institute burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t						
P.O. Box 68	Physician: The law requires that the death certificar this certificate has been signed by the attending phral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnate 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of degree of the second seco	I death 3 Ectopic	c pregnancy (specify)			23d. Date of deli Month	ivery Day Year
rds, P.	w requires that I been signed by should be deta	by	Part II. Other significant conditions con	ntributing to death but not res	ulting in the underlyin	ng cause given i	n Part I.		cco use contribute to 2 □ No 3 □ Pr	the cause of death?
al Reco	sician: The law re certificate has be- irector, page 2 sho	Completed							prior to d	topsy findings available completion of cause of 2 No
Division of Vital Records,	To the Hospitel or Attending Physician: The lwithin 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ition: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 Inpatient 2 (Month, Day Year)	ER/Outpatient 3 D 28b. Time of Injury M	DOA Other: 28c. Injury at Work?	4 Nursing Hor	(Check only one) ne 5 Residence 28d. Describe how	e 6 Other (Specinjury occurred	cify)
Divisi	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, street, fac fy)	etory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	iral Route Number,
	To the Hospitel within 24 hours. To the Funeral completely filled	Medical		sician: To the best of my knowner: On the basis of examina and manner stated.	ation and/or investigat	tion, in my opini	on, death occurre	ed at the time, date	and place, and due	to the cause(s)
	To t To t	×	29b. Signature and the of certifier	leng, M.O.		29c. License no		290	Date signed (Month	h, Day, Year)
	5 X		30. Name and address of person who co	- 11	n 23a) (Type, Print) Sicence Stre	iet N3	W62 1	Baltiner,	MO 212	5)
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature	-				

		1	For State Registrar	State of Maryla		artment of H tificate of			giene2001	. 01911
	Physicia		1. Decedent's Name (First, Middle, Last) SENORA	WH	ITFIELI)		2. Date of Dea Month JAN	Day Yee 20 2004	3. Time of Death P _M
)	/Medic Examin	er	4a. Facility Name (If not institution, give s NATIONAL NAVAL M. 5. Social Security Number 6. Sex	EDICAL CENTE	R: last birthday)		THESDA	8 Date of Birt	4c. County of De)MERY
	Funeral Director		226-42-2976	M 2⊠F 86	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Day 02 26		irthplace (State or Foreign Country) hmond, VA.
	Aaryland f ehow	or	Usual Residence of Decedent 10a. State 10b. County D • C •		city, Town or Lo Washing					10d. Inside City Limits
	with the ? 3a or 28a-	i Director	10e. Street and Number 1814 T Street N.1	J		10f. Zip Code 20009			10g. Citizen of What to	Country?
36	should be filed within 72 hours after death with the Maryland of Mental Hygene. marked other than "natural, or itama 23a or 28a-f show implied event, the Medical Exercitinar most be notified at	by Funeral		N ● 12. Was Decedent Ever in Armed Forces? 1		Was Decedent of I	dispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race - Ar Black, WI Specify: B1	
Maryland 21215-0036	filed within 72 hou Hygiene. other then "nature ent, the Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation a completed) College (1-4or 5+)	(Give	DO NOT use retire	during most of works	ing	16b. Kind of Busines Hospital	ss/Industry
and z	nould be filed withir I Mental Hygiene. narked othar than natic event, the Mi	To Be Co	17. Father's Name (First, Middle, Last) Charles L. Johnson	. 4	<u> </u>	Nurse	18. Mother's Name		Maiden Sumame)	
Mary		ř	19a. Informant's Name/Relationship (Ty Chantal Whitfield	pe, Print)		_	and Number or Rura	I Route Numbe	D.C. 2000	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other tra once.		20a. Method of Disposition 1 ☼ Burial 2 ☐ Cremation 3 ☐ P 1 4 ☐ Donation 5 ☐ Other (Specify)		cemetery, crer	stion (Name of matory or other pla n Nationa	ce)	Oate ·04	20c. Location - City Arlington	
Balt	permit. Departr Importa any inji		21. Signature of Funeral Service Licens	hall	4:	217 9th.	St. N.W.	Washing	Funeral I ton, D.C.	20011
145	Physician and Medical Examiner sthe partial-transit	i Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		PSIS equence of): equence of):	er the mode of dyl	ng, such as cardiac o	or respiratory ai	rrest,	Approximate Interval Between Onset and Death
.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	d	tal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of a	delivery Day Year
Δ.	quires that n signed b uld be deta	ed by Pl	Part II. Other significant conditions co	ntributing to death but not r	esulting in the u	inderlying cause gr	ven in Part I.			to the cause of death? Probably 4 □Unknown
Vital Records,		Completed							osy prior to ormed? death	autopsy findings available o completion of cause of ? es 2 \(\) No
Vita	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner? 1 Yes X No	Hospital: 1 XInpatient 2	☐ ER/Outpatie	nt 3 DOA Ot	26. Place of Deat		one) dence 6 Other (S	pecify)
Division of	g Ph ter th	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Inju			how injury occurred	
Divis		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe	home, farm, st cify)	reet, factory, office		28f. Location (City or To	Street and Number or wn, State)	Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examione)	sicien: To the best of my k ner: On the basis of exam- and manner stated.	nowledge, deat ination and/or in	h occurred at the t ivestigation, in my	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and manner date and place, and c	as stated. fue to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	? /	mn		se number		29d. Date signed (Mo	onth, Dey, Year)
	6		30. Name and address of police who co			Print)		IONAL N	AVAL MEDIC D 20889-56	
4	St Regist	ate rar	MICHAEL R. BAYDA 31. Date filed (Month, Day, Year)	32 Registrar's Sig	1.2	and s	Dr.I.	LLUDA II	20009 30	

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Mar	yland /			of Hea			iene2006 og. No.	+ 01912			
	Physici	an	1. Decedent's Name (First, Middle, Last) William George	Wantland						2. Date of Deat Month January	Day Yea	3. Time of Death 9:04 P M			
1	/Medio		4e. Fecility Name (If not institution, give s			1	4b. City,	Town, or Lo	cation of Death		4c. County of De				
	LAAIIIII	C1	1905 Swift Fox C				7	allst	ton		Harf	ord			
	Funeral Director		5. Social Security Number 6. Sex 219-34-4636	M 2□F	(In yrs. last b	oirthday) Yrs.	If Under Months		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 24,	9. 8 1940 Mo	irthplace (State or Foreign Country) Vryland			
	pu *		Usual Residence of Decedent 10a, State 10b, County	1	10c. City, To	wn or Lo	cation					10d. Inside City Limits			
	Maryli f sho	io	Maryland Harford	1		1	alls	ton				1 ☐ Yes 21 No			
	r 28a-	Directo	10e. Street and Number				10f. Zip			1	0g. Citizen of What	Country?			
	th with		1905 Swift Fox Ca	t.					047		u.s.A.				
36	172 hours after death with the Maryland *natural*, or Items 23s or 28s-f show rdical Exactions must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		1	Vas Deced Yes, spec		anic Origin? (S Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Black, WI	nerican Indian, nite, etc. White			
21215-0036	thour stural'	ed b	15. Decedent's Educ	Year or Dates:	16	ia. Deced	ent's Usua	I Occupatio	on ,		16b. Kind of Busines				
215	within 72 ene. then *na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	,	(Give	kind of wor OO NOT us	rk done duri se retired)	ing most of wor	rking					
	filed with Hygiene other tha	Com		1		Owne	r				Bar/Rest	aurant			
Maryland	be filed tal Hygie d other	Be	17. Father's Name (First, Middle, Last)	Wantland						ne (First, Middle, M Viola H					
<u>₹</u>	should be ind Mental marked o	ဥ	William George 19a. Informant's Name/Relationship (Ty)	Wantland	10	9h Mailin	a Address				, City or Town, State	Zip Code)			
<u>a</u>	C1 00 = 00		Mrs. Jessica J. Wo				-				, Marylano				
ē,	s 1 and f Health item 27 other to		20a. Method of Disposition		20b. Place	of Dispos	sition (Nan				20c. Location - City				
altimore,	- 0 .		1 ☐ Burial 2 【X Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ſ	. *		tory	1/2	6/2004 1	Baltimore,	Maryland			
Balti	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service License	90							uneral Ho Le. MD 21				
	8		9705 Belair Rd., Baltimore, MD 21236 23a Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximation of the disease of the deeth of the de												
	Physician		Immediate Cause (Final disease or condition a. 5 mal Cell Lung Cancer 15 mont												
	/Medical		resulting in death)	Due to (or as a	consequenc	e of):		7			.,,	10.500			
>	Examiner	L	Sequentially list conditions,	Due to (or as a	00000000000	n off:									
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or 25 a	consequenc	.a 01).									
	al-trai	xar	that initiated events cresulting in death) Last	Due to (or as a	consequenc	e of):						-			
58760,	ficate be executed physicien and is the burial-transit	edicai I		J											
_	tificat ng phy as th		IC CELLUI C												
Вох	The law requires that the death certif ite has been signed by the attending page 2 should be detached for use an	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 Live birth 2	Fetal dea		Ectopic pr				23d. Date of o	lelivery Dav Year			
0.	at the dea by the at tached fo	/sici	1 Yes 2 No	4□Pregnant at ti 9□Unknown	me of death	5 🗆	Other (sp	ecify)							
О.	that the ed by detac	Ph.	Part II. Other significant conditions con	ntributing to death but	not resulting	g in the ur	nderlying c	ause given i	in Part I.	23e. Did tob	oacco use contribute	to the cause of death?			
ds,	uires that signed k ld be det	d by								1 X (Ye	as 2□No 3□	Probably 4 Dunknown			
Records,	w require s been si should I	Completed								24a. Was a	n 24b. Were	autopsy findings available			
	The law	E O								autops perform 1 ☐ Yes 2	ned? death				
ta	ician: Th certificate ector, pag	BeC	25. Was case referred to medical					2	6. Place of Dea	ath (Check only on					
<u>></u>	Physician: r this certific ral director,	To E	examiner? 1 ☐ Yes 2 X No	lospital: 1 Inpatient							ence 6 Other (S)	pecify)			
Division of Vital	After After fune		27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day		o. Time of Injury	м 2	8c. Injury at Work? 1 ☐ Yes	s 2 □No	28d. Describe ho	ow injury occurred				
Divis	F # F C	Certifications	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.		farm, str	eet, factory	, office		28f. Location (St City or Town		Rural Route Number,			
	To the Hospital of within 24 hours at To the Funerel D completely filled in	Medical C		sicien: To the best of ner: On the basis of a and manner state	xamination										
	To th Within To th	Me	29b. Signatur, and title of certifier	. 17	E		1000	. License n			9d. Date signed (Mo				
			V fulled to	akmer	ME	3	1	000	51770	J	anuary =	23 2004			
	51	-	30. Name and address of person who co	empleted cause of dea	ath (Item 23a	а) (Туре,	Print)	1	211.	. 11	, ,	23 2004			
	\		31. Date filed (Month, Day, Year)	32. Registrar	O Or				Dalti	more Ma	syland e	71251			
	Sta Regist		31. Date filed (Month, Day, Year) JAN 2 7 2004	Sens sens	13	14	DOLK!	23							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 8 per fh 1845 7-15-05 vt. State of Maryland / Department of Health and Mental Hygiene 1 1 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:10 22, 2004 Wiser January Patricia Lee /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Bayview Medical Center Bairrivior E

Sex 7. Age (In yrs. last birthday) Hunder 1 Year If Under 24 Hrs. Months Days Hours Min. April 4, 1943 Examiner Baltimore Hopkins Birthplace (State or Foreign Country)
 D. 6. Sex 5. Social Security Number **Funeral** 219-40-3614 Director Usuat Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f ahow any injury or other traumatic avent, the Medical Examiner must be notified at once. 10d. tnside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ H6 Dundalk BALTIMORE MD Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S. KKW AY Funeral Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Maritat Status Black, White, etc. 1 Yes 2 No tf Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIF 6 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) RANK ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2(222 TASMINE 2106 daygnes KIM Berly 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition-1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MD 123109 new ⁴ 4 □Donation 5 □ Other (Specify) 21. Signatural of Funeral Service Licenses 22. Name and Address of Facility 2,222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5 hours Pulmonary
Due to (or as a consequence of): **Physician** Embolism /Medical Examiner Pneumonia Sequentially tist conditions, if any, leading to immediate cause Enter the best of Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and the burial-transit Coll Due to (or as a consequence of): Box 68760. Physiclan/Medical use as the tF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day į 4□Pregnant at time of death 5 ☐ Other (specify) P.0. detached 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 ☐ Probably 2 🗆 No 4 DUnknown Hupertension, Depression Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2D No 1 Yes To the Hospitel or Attending Physician; 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospitat: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 2 this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours after To the Funeral Direct 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investination, in my onicion, death occurred at the 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES -January 22, 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Baltimare 21224 . Vera 31. Date filed (Month, Day, Year) 32. Segistrar's Signature State 2004 Registrar Stork

ORIGINAL

			1 - For State Registrar	State of Maryland / Department / Ce	artment of Health and I <i>rtificate of Death</i>	Mental Hygier	C004 01710
	Dhamini		1. Decedent's Name (First, Middle, Las	')	14	2. Date of Death Month	3. Time of Death
	Physici /Medio		STANLEY		WIGGINS	January	15 Seoy 9:30 AM
	Examin	er	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		tc. County of Death
		- 3	5. Social Security Number 6. Se	x 7. Age (In yrs. Mast birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplece (State or Foreign
	Funeral Director			M 2□F Yrs.	Months Days Hours Min.		955 A. CAROURA
		'	Usual Residence of Decedent	70		19/1	100 M.CAROURE
	how how		10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	Ba-fs	cto	Horylows N/	b BP	1truere		1 Nes 2 □ No
	iff th	Director	10e. Street and Number	M .	10f. Zip Code	10g. (Citizen of What Country?
	s 23s	Funerai		12. Was Decedent Ever in U.S. 13.	Was Davided of Historia Origin 2 (6	nositu Van ar Na	14. Race - American Indian,
	Item Item	-un	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White, etc.
936	urs af	by	Widowed 4 □ Divorced	t dyes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify; Black
215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show that the Medical Esarch art must be rediffed at	Completed by	15. Decedent's Ed (Specify only highest grad		dent's Usual Occupation skind of work done during most of wor	king 16b.	Kind of Business/Industry
2	ithin	npie	Elementary/Secondary (0-12)	College (1:4or 5+)	DO NOT use retired)		4
7	ygier ygier her th	S	12Hgrade	640	omen		ee Track
and	be fi	Be	17. Father's Name (First, Middle, Last)	biggins		ne (First, Middle, Maid	en Sumame)
Maryland	should ind Men in marke umatic	2	19a. Informant's Name/Relationship (7		ing Address (Street and Number or Ru		v or Town State Zin Code)
<u>8</u>	and 2 sealth an n 27 is		Coustal WEAVE	e/Doughter 520.			NUR Hedaldis
ē,	f Hea f Hea item othe		20a. Method of Disposition	20b. Place of Dispo	osition (Name of matory or other place)		Location - City or Town, State
Ë	Peges nent of I ant: If its ury or o		Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	mel Concher !	21/04	world, Marelows
altimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Example Hindal be notified at ORGE.		21. Signature of Furieral Service vicent	See 2:	Name and Address of Facility	ATMAR-L	
<u></u>	88 = 88		I ferry for	× ?	340 REISTESTA	1215	
			23a. Part. Enter the disease, or compensate, or heart failure. List only of	lications that caused the death. Do not en one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
e Va	Physician	,	Immediate Cause (Final disease or condition	a CIRRHUSIS			Onset and Death 4cars
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):			
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<u>,</u>	execunand nand ial-tra	Examin	that initiated events resulting in death) Last	C. Due to (or as a consequence of):			years
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9	rtifical ng phy as th	0	Is service				
Вох	th cer tendir r use	an/N	23b. was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 [DEctopic pregnancy		23d. Date of delivery
о. П	that the death certificed by the attending of detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Other (specify)		Month Day Year
<u>a</u> .	d by detach	F.		ontributing to death but not resulting in the u	underlying cause given in Part !	23e Did tobacco	use contribute to the cause of death?
Records,	8	1 by	Tarris office significant conditions of	intributing to doubt but not 1930(ing in the b	indertying cause gives in rails.	1 ☐ Yes	5 /
Ö	w requir been si should i	ete				24a. Was an	24h Wara autoney findings available
Rec	he lav e has ige 2	Completed				autopsy performed?	
Vital			25. Was case referred to medical		26 Place of Des	th (Check only one)	No 1 Yes 2 No
		To Be	examiner?	Hospital: 1 Inpatient 2 ER/Outpatien	Othor	ome 5 Residence	6 ∏Other (Specify)
0			27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		28d. Describe how in	
Ö	Attending it death. ector: Afte by the fune	atic	2 ☐ Accident investigation		M 1 ☐ Yes 2 ☐ No		
Division of	I or Attendater death Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the		200 Cartillar "NTCartifular Dis	minima. To the beat of an income decided			
	To the Hospital within 24 hours a To the Funerel I completely filled	edical	29a. Certifier Certifying Phy (Check only one) Medical Exam	/sician: To the best of my knowledge, deat iner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place evestigation, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as stated. Ind place, and due to the cause(s)
	othe othe omple	Me	29b. Signature of certifier	/	29c. License number	29d. [Date signed (Month, Day, Year)
	->-0		felling.	1+	RES-000	ha	waru 15 2004
	Vin			mpleted cause of death (Item 23a) (Type,	Print)	- Cur	9,0,200
	The state of the s		Kelly Brungai	dt 1830 E. Monun	vent St 9th Flow	r Baltin	wary 15,2004 were MD 21287
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 6 2004	32. Registrar's Signature	P		
	ricgiali	.1	CUU4	1	Al Care sell 1		

			1 - For State Registrar	State	of Marylan		artmen			and M		jiene leg. No.	2004	01915
	Dhusisi		Decedent's Name (First, Midd	le, Last)							2. Date of Dea Month		Year	3. Time of Death
	Physici /Medio		Mary Evely	n Wine	miller						Januar	y 24	, 2004	12:15 ₽ ^M
	Examin		4a. Facility Neme (If not institution	n, give street and n	umber)				Location of			4c. (County of Death	1
			The Wesley						ore C				n/a	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs.		If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birtl (Month, Day	Year)	Co	nplace (State or Foreign
	Director		218-34-0341	I I I W Z JEN I	95	Yrs.					Sept. 2	4, 1	908 N	Maryland
	and *		Usual Residence of Decedent 10a. State 10b. County	,	10c. Cih	y, Town or Lo	cation							10d. Inside City Limits
	Aaryli sho	ō												1 Tes 2 No
	28a-	ect	MD Balti	more		Tow	50N 10f. Zip	Codo			1.	On Citin	en of What Co	
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	eath	era	730 Cambe:		cedent Ever in U.	S 13 1			snanic Ori	ain? (Sne	ocify Ves or No-		4. Race - Amer	
	ter d	-un	1 Never Married 2 Mar	Armed I			f Yes, spec	fy Cuba	n, Mexican	. Puerto	cify Yes or No- Rican, etc.)	'	Black, White	, etc.
33	urs al	by Funeral Director	3 ☑ Widowed 4 ☐ Divorced	If Yes (Give		1 ☐ Yes 2	No.	Specify:				Specify:	White
ŏ	2 hou	Completed	15. Deceder	nt's Education			dent's Usua					16b. Kin	d of Business/l	ndustry
215	hin 7	ple	(Specify only higher Elementary/Secondary (0-12)		(1-4or 5+)	(Give	kind of wor DO NOT us	k done d e retired,	luring most)	t of worki	ng			
7	d with	EIO.	11	00,1090	(1 40/ 5/)	Ho	memak	er				Ot	un Home	
פ	al Hy other	Be (17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middle,	Maiden S	Sumame)	
<u> a</u>	uld b Ments urked itlc e	70	George M. Sut	er					Mar	y E	lizabeth	ר Ma	allone	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-1 show aumatic event, the Medical Examination and be notified at	\$ 33	19a. Informant's Name/Relations			19b. Mailir	ng Address	(Street a	ind Numbe	r or Rura	Route Numbe	. City or	Town, State, Z	
2	and and n 27		Beverly Roesle	r/daughte					rircl	e Ap	t. A4 To	וספשכ	עויו, ר	21 204
ore	of Heritary		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 DRamoval from		lace of Dispo emetery, crer	sition (Nam natory or of	ne of ther place	9)	С	ate	20c. Loc	ation - City or I	Town, State
Ĕ	Pag nent ant: J ury o		`4 □Donation 5 □ Other (S			ຢlawn ເ	Cemete	ery	01/3	28/21	004 I	Balt:	imore,	MD.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examinar must be multipled at once.		21. Signature of Funeral Service	Licensee			. Name and				Ruck To on, Mary			l Home, Inc. 4
			23a. Part1. Enter the disease, o shock, or heart failure. List	complications that	caused the death	n. Do not ent	er the mode	of dying	g, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Cerebro		ar Ac	cide	ent					Onset and Death 2 Weeks
3	Examiner			1	Hyperte		Cereb	rova	scula	ar Di	sease		1	Years
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	cuted nd ransit	Examiner	that initiated events	C.										
ó	an ar irial-t	EX	resulting in death) Last	Due to	o (or as a consequ	uence of):								
8760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	cal		d										
39	ing pt	Physiclan/Med	IF FEMALE:					-						
Box 6	w requires that the death certific been signed by the attending p should be detached for use as	an/	23b. Was decedent pregnant in the past 12 months?		utcome of pregna birth 2 Petal		Ectopic pre	agnancy				23	3d. Date of deliv	
E	e dea he at ied fo	sic	1 ☐ Yes 2 🔀 No	4 ☐ Preg 9 ☐ Unk	gnant at time of de		Other (spe					į	Month	Day Year
P.O.	at the	Phy	9 Unknown											1
Ś	es th ignec	by	Part II. Other significant conditi	ons contributing to age Demen		ulting in the ur	nderlying ca	iuse give	n in Part I.					the cause of death?
ord	equil	ted	- Lind 50	age beinen							1 ∐ Y	es 2 🖸	No 3 □ Pro	bably 4 Unknown
Records,	has b	Completed									24a. Was a autops			opsy findings available ompletion of cause of
	The cate h	Con									perfori 1 ☐ Yes	ned?	death? 1 ☐ Yes	
/ita	cian: ertific actor,	Be	25. Was case referred to medica examiner?								(Check only on			
5	hysi this o	2	1 ☐ Yes 2 🛣 No		Inpatient 2 1			A Othe	4 🔀 Nur	rsing Hon	ne 5 ☐ Reside	ence 6	Other (Speci	(fy)
בַ	ing P	0	27. Manner of Death 1 X Natural 5 ☐ Pendii	28a. Date (Mo	e of Injury onth, Day Year)	28b. Time of Injury		3c. Injury Work	?		8d. Describe ho	w injury	occurred	
<u>s</u>	tend death tor: /	cat	2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	not bo			М		′es 2⊡N	12				
Division of Vital	or At	Certification:	4 Homicide determ	nined 28e. Plac	ce of Injury - At ho ding, etc. (Specify	me, farm, stre	eet, factory,	office		2	8f. Location (SI City or Town	reet and , State)	Number or Rur	al Route Number,
	pital urs a eral [00 - C-+151-	- British										
1	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier 1 △ Certifyii (Check only 2 ☐ Medicel one)	ng Physician: To the Exeminer: On the and ma	ne best of my know basis of examinat nner stated.	wieage, death ion and/or inv	occurred a estigation.	in my op	e, date and inion, deat	place, a	nd due to the ca d at the time, d	ause(s) a ate and p	nd manner as s place, and due t	stated, to the cause(s)
	To th Fo th	Me	29b. Signature and title of certifie	-01		w	29c.	License	number		2	9d. Date	signed (Month,	Day, Year)
	,		Elebert E.	16thm	MD		D	-194	25			1	/26/04	
	5		30. Name and address of person	who complete	use of death (Item	23a) (Type.	- 1					-	, _0, 0 }	1 1100
		- 1	Robert E. Rol		2211 W.R			Ba1	timor	e, N	1d. 2120	19		
	Sta		31. Date filed (Month, Day, Year,		Registrar's Signat	ture	201							
3	Registr	ar	JAN 27	2004	Muss L	H Again	affer							

			1 - For State Registrar	State of M	aryland		artmen rtificate			and M		giene g	200	4 01916
	Physici /Media		1. Decedent's Name (First, Middle, Last Frances	"		We	iner	`			2. Date of Dead Month Junu	ath and ay 2	4 200	3. Time of Death
<i>)</i>	Examir		4a. Facility Name (If not institution, give	unty 6	every	Hosp	4b. City,	(Location of	mb	un		unty of Dea	vard
	Funeral Director		5. Social Security Number 6. Se 215-18-6538 10	M 2 KF 7. AG	98 (in yrs. 18	Yrs.	Months	Days	Hours		8. Date of Birt MAYOnth, 92	² 1 9 20	9. Bir	thplace (State or Foreign
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Maryl a-f ehc	į	MD BALTIMOR	Ε.	BALT	ΓΙΜΟRΕ								1 Yes 2 No
	th with the 23a or 28 ast be not	al Director	10e. Street and Number 6705 CHOKEBERRY R	OAD			10f. Zip 212	Code 09				10g. Citizen USA	of What C	ountry?
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f ehow important: If item 27 is marked other then "natural", or items 23a or 28a-f ehow appringly or other traumatic event, the Madical Examinational by multified at ance.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 24 If Yes, Give Year or Dates:)		Was Deced if Yes, spec 1 Yes 2	offy Cuba	spanic Orion, Mexican Specify:	gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)	ţ	Race - Am- Black, Whi ecify:WHI	
5-0	natu	letec	15. Decedent's Edu (Specify only highest grad			(Give	dent's Usua kind of wor DO NOT us	k done a	lurina most	of working	ng	16b. Kind o	of Business	s/Industry
212	d withir giene. ir then	Completed	Elementary/Secondary (0-12)	College (1-4or !	5+)	HOMEM		e reureu,	,			OWN H	IOME	
nd	be filed tal Hyg d other	Be	17. Father's Name (First, Middle, Last)	00051.5	. N.D.						(First, Middle,			
IZ	should and Men a marke umatic	မ	AARON 19a, Informant's Name/Relationship /Ti	COPELA voe. Print)	AND	19b. Mailir	ng Address		FLORA		/ Route Numbe		RIS	Zin Code)
ĭ, ⊠	1 and 2 s Health ar lam 27 is		19a, Informant's Name/Relationship (T MR. MORTON WEINER/	HUSBAND		6705	CHOKE	BERR	Y ROA	D BA	I Route Numbe LTIMORE	,MD.2	1209	2.p 000e)
Baltimore, Maryland 21215-0036	Pages 1 and nent of He int: If itam		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Specify,		BETF	ace of Dispo metery, cred	sition (Name Baton ON	ne of ther place G •	9) 1/	25/2	004	20c. Locati FINKS		Town, State MD .
Bait	permit. Departn Imports any injk		21. Signature of Fune at Service Licens	*		89	Name and	d Addres ISTE	s of Facility RSTOW	in ^o ko	AEVI NS	Ns%ıB	ROS,MD	INC 21208
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*	/Medical Examiner		resulting in death)	a Due to (or as	a consequ	ence of):	// 1	1.	- 0	- 11	. 01			
. ja 180		er	Sequentially list conditions,	Due to (or as b. Due to (or as c. Due to (or as	a consequ	nou ult	My	141	my	cle	ma			
	acuted nd transit	Examiner	Sequentially list conditions, I any learn a conditions cause. Enter Underlying Cause (Disease or injury that initiated events	c	CI	non	ri 1	ren	al	Xal	lure	,		
8760,	icate be executed physician and the burial-transit	dical Ex	resulting in death) Last	Due to (or as	a consequ	ence of):			()				
မှ	entifica ling ph e as th	Med	IF FEMALE:	20. 1	,		in a second							
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal	death 3	Ectopic pre Other (spe					23d.	Date of de Month	livery Day Year
	res that igned b be deta	by	Part II. Other significant conditions co	ntributing to death b	out not resul	Iting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco use o	contribute to	o the cause of death?
Records,	w require been si should b	eted	- Dualed	anuw r	1101.	Jeun	<u>y</u> .	,		- :		es 2□N		robably 4 Unknown
	sicien: The law s certificate has b lirector, page 2 s	Completed	delubition	o will	en	0,000	lul				24a. Was a autop: perfor	sv	prior to death?	utopsy findings available completion of cause of
Vita	/siciar s certif directo	To Be	25. Was case referred to medical examiner?	Hospital: 1 💢 Inpatie	ant 2∏E	R/Outpatien	t 3□ DO.	A Othe			(Check only or ne 5 ☐ Resid		Othor (Car	noife!
Division of	ding Phys h. After this funeral di		27. Manner of Death	28a. Date of Inju (Month, Da		28b. Time of		Bc. Injury Work			8d. Describe h			City)
Sio	ttendi death. ctor: A / the fu	catl	2 Accident investigation 3 Suicide 6 Could not be			no form st-	М	1 🗆 Y	es 2□N		94 topotion (C	tanat and blo		
<u>≥</u>	tal or A	Certification:	4 Homicide determined	28e. Place of Inj building, et	c. (Specity)	ne, iaini, sir	eet, factory,	, onice			City or Tow	n, State)	IMDOF OF HI	ural Route Number,
2	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one) Certifying Phy 2 Medical Exami	sician: To the best iner: On the basis of and manner sta	t examinati	rledge, death on and/or inv	occurred a restigation,	at the time in my op	e, date and inion, deat	d place, a h occurre	nd due to the c	ause(s) and late and plac	I manner as ce, and due	s stated. e to the cause(s)
1	Within To 11	×	29b. Signature and title of certifier	2	n		29c.	License		-7 ()				h, Day, Year)
•	.8		30. Name and address of person who co	ompleted cause of	leath (Italy	222) /7:	Oriot)	0	00	10	,	TRVIN	ayd	1029
	10		Suzan Abo	to 500	5 Si	Mal	Bell	12n	·a	Corli	sull	M	1 2	1029
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr		ite	OM K	2/						

		For State Registrer	State of Marylan	id / Depai		lealth and M	Mental Hygi	_	4 01917
Physi		1. Decedent's Name (First, Middle, Last)	e Walke				2. Date of Death Month January	Day Ye. 19.20	22 C 2 2 7 // /3 14
/Med Exam	iner	4a. Fecility Name (If not institution, give s 2220 Walbrook	K Avenue			Floration of Death		4c. County of D	eath A
Funera Directo		Usuel Residence of Decedent	7. Age (In yrs.	Yrs.	Months Days	Hours Min.	(Month, Oay,	rear) 31,1923 G	Birthplace (State or Foreign Country)
the Marylan 28a-f show	Director	Maryland N/A 10e. Street and Number	10e. Cit	Balti	10f. Zip Code		10	g. Citizen of What	10d. Inside City Limits 1 Xes 2 No
sath with	erai Dir	2220 Walb	OOK Aver 2. Was Decedent Ever in U	sue 12 W	21	2/4		U.S.1	4
ours after de rai', or item	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Yes, specify Cub	dispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		thite, etc. Black
ilied within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23e or 28e-f show ent. tra Medical Esabiner mult be routiled at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give ki	int's Usual Occup ind of work done O NOT use retire	during most of world)		Spring Mental	Grove
Man y railly & 1 & 1 & 1 & 1 & 1 & 1 & 1 & 1 & 1 &	To Be Co	17. Father's Name (First, Middle, Last)	max	1	70 0-4	18. Mother's Nam	ne (First, Middle, Middle, Middle, Middle, Middle)		1115/11/00/10
Pages 1 an ment of Heal ant: If item 2 ury or other		19a. Informant's Name/Relationship (Ty) Shelley D. Walke 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	Cranddaught 200. F	Place of Disposi cometery, crema od/awi	0 Walt	rock Ave	Date 20	City or Town, State It more Doc. Location - City Local Law Harn's f	MD 2/2/6 or Town, State
permit Depart Import any inj		23a. Pert 1. Enter the disease, or complishock, or heart failure. List only on	Arris	524	10-44 Re	sterstown	Road Ba	Himore	Approximate Interval Between Onset and Death
eath certificate be executed Ex A A A A A A A	cai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last	Due to (or as a consequence to (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or	uence of):	CINOMA	et Un	lenown (rrmavy	7 yv
hat the death certific d by the attending p	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of degree Unknown	ıl death 3 □E	Ectopic pregnance Other (specify)	1		23d. Date of Month	delivery Day Year
quires that the de n signed by the a uid be detached f	ed by Ph	Part II. Other significant conditions con	tributing to death but not res	ulting in the und	derlying cause giv	ren in Part I.			e to the cause of death? Probably 4 Unknown
The law recate has been cate has been cate has been cate has been cate has been cate has been cate has been cate has been categorially and categorial and categorial an	Completed						24a. Was an autopsy perform	prior ed? death	e autopsy findings available to completion of cause of 1? fes 2 \Bo
To the Hospitel or Attending Physicien: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phicompletely filled in by the funeral director, page 2 should be detached for use as the	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 I	ER/Outpatient 28b. Time of Injury	3 DOA Ott	er: 4 Nursing H	th (Check only one orne 5 Nesiden 28d. escribe how	ce 6 Other (S	Specify)
tel or Atter s after dea al Director	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stree fy)	et, factory, office		28f. Location (Stre City or Town,		r Rural Route Number,
To the Hospitel within 24 hours a To the Funeral (completely filled	Medical	(Check only 2 Medicel Examir	ician: To the best of my knower: On the basis of examina and manner stated.	owledge, death a tion and/or inve	estigation, in my o	pinion, death occur	rred at the time, dat	e and place, and	due to the cause(s)
To To To E	Σ	29b. Signature and title of centifier	mby mi		29c. Licens			JAN 2	
12/		30. Na and address of pers, in who co	UEY 900	CA	rint) TON A	VE B	ALTIMA	is m	2 2004
S Regis	tate trar	31. Date filed (Month, Day, Year) JAN 2 6 2004	32. Registrar's Signa	d A	parket				

Lindberg Ulys unknown 04	se !-(20 Please	Type or Print in	Black in	delible l	nk. Ensure A	II Copies	Are I	Legible.	
04-00509 DOS		1- State Unpend Item	#251ate29f Mary	agd _് ഉള്ള <i>Cei</i>	zyzento rtificate	of Health and N of Death	Mental Hy	giene Reg. No.	2001	01919
Physicia		1. Decedent's Name (First, Middle, La LINDBERG	151455GS W	ade			2. Date of De Month Janua:	Day	Year 3 2004	3. Time of Death 1307 p ^M
/Medic Examine		4a. Facility Name (If not institution, gi Maryland General	ve street and number)		4b. City, Tov Balti	wn, or Location of Death			County of Death	•
Funeral Director		Social Security Number 6.		vrs. last birthday) Yrs.	If Under 1 Y Months D	ear If Under 24 Hrs. ays Hours Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birth Cou	place (State or Foreign ntry) 4 / Marson
aryland ahow	Σ.	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo						10d. Inside City Limits 1 Des 2 □ No
ith the Marylar or 28s-f show)irecto	10e. Street and Number	1/	POIL	10f. Zip Co			10g. Citi.	zen of What Cou	intry?
er death w Itama 23a ner cuist b	Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in Armed Forges? 1 □ Yes 2 No If Yes, Give		1	1915 t of Hispanic Origin? (Si Cuban, Mexican, Puerto KNo Specify:	pecify Yes or No o Rican, etc.)		14. Race - Amer Black, White	
-003 2 hours atural; cal Erus	ted by	3 Widowed 4 Divorced	Year or Dates:	16a. Dece	dent's Usual C	Occupation	trian		nd of Business/I	ndustry
Maryland 21215-0036 d 2 should be filed within 72 hours all this and Mental Hygiene. 27 Is marked other than "natural", or traumatic event, the Madical Exami	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)	life.	BUTEN					Toustry
yland 212 buld be filed with Mental Hygiene arked other tha attc event, that	To Be	17. Father's Name (First, Middle, Las				18. Mother's Nam	E Brow		Sumame)	
Mary d 2 shou h and M 7 Is mar traumat	-	19a. Informant's Name/Relationship	(Type, Print) / SISTER		1.	treet and Number or Ru	7 11		Town, State, Zi	
Baltimore, M sernit. Pages 1 and 2 Separtment of Health is moorant: if team 21 in iny injury or other tre once.		20a, Method of Disposition 20a Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	☐Removal from State	b. Place of Dispo cemetery, cred	sition (Name matory or other	of	Date 2 4/64	20c. Lo	cation - City or T	
Baltimore permit. Pages Department of P Important: if its any injury or of		21. Signature of Funeral Service Light	ensee	5	240 R	Address of Facility	KLAD			
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Physician /Medical Examiner		Imm ate Cause (Final disease or condition resulting in death)	a. Sepsis Due to (or as a con		Chronic	Narcotism				
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cords, P. (w requires that the bean signed by should be detact		Part II. Other significant conditions	contributing to death but not	t resulting in the u	inderlying caus	se given in Part I.			. /	the cause of death?
e la	Completed						24a. Was auto perf 1 Yes		24b. Were aut prior to c death? 1 Dres	opsy findings available ompletion of cause of 2 No
f Vital F vysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner? 1 [XYes 2 □ No	Hospital:	2 ER/Outpatie	nt 3(XDOA	26. Place of Dea			5 □Other (Spec	ifv)
on of ling Phy	on: To	27. Manner of Death	28a. Date of Injury (Month, Day Yea		of 28c	. Injury at Work?	28d. Describe			
- 5 5 5 E	Certification:	2 Accident investigate 3 Suicide 6 Could not 4 Homicide determine	be Ope Place of Injuny	At home, farm, st pecify)	reet, factory, o		28f. Location City or To	(Street an wn, State	d Number or Ru)	ral Route Number,
To the Hospital of within 24 hours at To the Funeral D completely filled in	edical Ce	29a. Certifier 1 Certifying I (Check only one) 2 Medical Ex	Physician: To the best of my eminer: On the basis of exa and manner stated.	knowledge, deal mination and/or in	th occurred at nvestigation, in	the time, date and place my opinion, death occu	a, and due to the urred at the time	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
To the within To the complex	Me	29b. Sign-tu e and title of certifier	re Yhele	up	29c. L	ocmE	-		e signed (Month lary 19	
		30. Name and address of person who	o completed cause of death	(Item 23a) (Type	Print) 111	Penn Stree	t, Balt	imore	e, Maryl	and 21201
Sta Registr		31. Date filed (Month, Day, Year) JAN 2 6 2002	32. Registrar's S		Spark					

	State of Maryland / Department of Health a Amend Item #5 per informant G831 5/12/04 tas Certificate of Death	and Mental Hygiene 2004 01919
	Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year
Physician /Medica	RAILY & CUHRETINE XIVINES	January 14 2004 10:15 am
Examine	4a Facility Name (If not institution, give street and number)	wn, or Location of Death
	FOREST HAVEN NURSING HOME 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
Funeral Director	116 18 4063 1 M 2 TF 95 Yrs. Months Days Hours Usual Residence of Decedent	Min. APR. 14, 1908 MARYLAND
ylend mov	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
e Mar	MD BALTIMORE CATONSVILLE	1 ☐ Yes 2 X No
章 2g 章	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
s 23e	701 EDMONDSON AVENUE 21228 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ori	U.S. OF A.
15-0020 72 hours efter death with the Marylend "naturel", or flerne 23e or 28e-f show sideal Examiner must be notified at	MD BALTIMORE CATONSVILLE 10e. Street and Number 7 0 1 EDMONDSON AVENUE 11. Marital Status 1 Never Married 2 Married 3 M Widowed 4 Divorced 10f. Zip Code 2 1 2 2 8 11. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Specify Cuban, Mexicar of Hispanic Ori If Yes, specify Cuban, Mexicar of Dates: 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No	
15-002	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during mos	t of working
- c - 3	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6TH GRADE 15a. Decedent's Usual Occupation (Give kind of work done during mos life. DO NOT use retired) SUPERVISOR	METAL WORKS FACTOR
A tygier w	6 TH GRADE UNKNOWN SOFERVISOR 17. Father's Name (First, Middle, Last) 18. Mothe	or's Name (First, Middle, Maiden Surname)
ire, Maryland 212: s 1 and 2 should be filed within t Heelth end Mental Hygiene. ttem 27 is marked other than other traumatic event, the M	DOCE	Y WHITEN TAYLOR BELL (DECEAS
Maryland d 2 should be file th end Mental th end Mental the marked oth traumatic event		er or Rural Route Number, City or Town, State, Zip Cod 21042
Magning 2 27 la 27 la	DR JACALYN BLACKWELL-WHITE 9145 STAY	YMAN DR. ELLICOTT CITY, MD.
0 00 = =	20a Method of Disposition 20b. Place of Disposition (Name of	Date 20c. Location - City or Town, State ARK 1/22/04 ARBUTUS, MARYLAN
Baltimo permit. Pag Depertment Important: It any Injury o	21. Signature of Funeral Service Licensee LEWIS T. GWYNN LEWIS T. GWYNN LEWIS T. GWYNN 4517 PARK HE	NN FUNERAL HOME 21215-6393
HERVINE	23a. Part1. Enter the disease, or complications the sused the death. Do not enter the mode of dying, such as shock, or heart tailure. List only one cause in each line.	
Physician	1	Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. ATHEROSCLEROTIC CERE	BRO VASCULAR, DISEASE
	Due to (or as a consequence of):	
uted Insit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	
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68760, cata be ex physician tha burial	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
C 68 artifica ing ph e as ti	1050kiilig iii Obakii) Last	
that the death certification by the attending a detached for use as		
the deay the a	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	
IS, P.O. es that the igned by the be detache		1 Yes 2 No 3 Probably 4 Unknown
cord requir		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
The la ata has page 2	5	1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No
Of Vital Physician: T		of Death (Check only one)
Of Vita Physician: this cartific and director,	1 Yes 200 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 No.	ursing Home 5 ☐ Residence 6 ☐ Other (Specify)
ng Pl		28d. Describe how injury occurred
DIVISION C tal or Attending Pi rs aftar death. eld in by the funera	2 Accident investigation 3 Suicide 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Hospi Hospi Funer tely fil	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date an and manner stated.	
To the Vithin 2 To the comple	29b. Signature and title of certifier 29c. License number D 2859	29d. Date signed (Month, Day, Year)
10	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THS NEEM (AKITANI, 7220 FARK 1+E)	COHO AVE, BALTO MARLES
State		
Registra	JAN 2 7 2004 Server 15 Aproches	

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** January 23, 2004 10:35 A Richard Lee Yeagle, Sr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Timonium

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. (Month, Day, Year)

Nov. 23, 1 Baltimore Stella Maris 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** 1⊠M 2□ F 93 Yrs 1910 Maryland 213-03-4080 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a, State 10b County ral, or items 23a or 28e-f show Examiner past be notified at 1 ☐ Yes 2 X No Baltimore Timonium Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21093 United States 10 Gorsuch Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status hours after 1 ☐ Never Married 2 X Married White 1 Yes 2 No Specify: Specify: δ 3 Widowed 4 Divorced "natural", Completed ir then "natural 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) 12 Purchasing Agent Koppers Company is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Grace Burgee Lawrence G. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Timonium, Maryland 21093 Charlotte M. Yeagle/wife 10 Gorsuch Road 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If Itel
any injury or ott 1 Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem. 01/26/2004 Timonium, Maryland 22 Name and Address of Facility Ruck Towson Funeral Home, Inc. 01/26/2004 Timonium, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungilal Service License 1050 York Road Towson, Maryland 21204 23a. Part. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) Physician END STAGE DEMENTIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, bading to initial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner law requires that the death certificate be executed burial-transit attending physicien and Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 ∏Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? The 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No certificate Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 X Natural М 1 ☐ Yes 2 ☐ No death. 2 Accident hours after deat filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō To the Hospitel of within 24 hours at To the Funerel D Hospitel 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number 11-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

a.

10:30

21215-0036

Maryland

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Box 68760.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2004 Certificate of Death 2. Date of Death nt's Name (First, Middle, Last) Month 05 **Physician** 2001 /Medical 4c. County of Death Location of Death Name (If not institution, give stre Examine Birthplace (State or Foreign Country)
 VA Age (In yrs. last birthday) If Under Date of Birth (Month, Day, Year) 2 09 5. Social Security Number **Funeral** Days Months 1 □ M 2√□ F 81 Yrs 220-22-6693 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Baltimore NA Directo 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code U.S.A. 2221 Bryant Ave 21217 or Items 23a Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ 3€Vidowed 4 Divorced Black "natural" Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If Item 27 is marked other th any injury or other traumatic avant, Itta QDG. 8th grade Domestic Private Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lucille Smith Pansy Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 21244 7926 Dunhill Village Circle, #204, Baltimore Delores Lee-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Mala 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Garrison Forest Vet. 1/30/04 Owings Mills, Md 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee March 4300 Wabash Ave, Baltimore Md 21215 23a. Part1. Enter the disease or comshock, or heart failure. List only complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Asser and Death each Immediate Cause (Final disease or condition resulting in death) JOUY Physician /Medical Due to for as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for the sea or the busing transmitted. Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown it II. Other significant conditions could uting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 ☐ No 1 ☐ Yes 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No Hospital: Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Watural 2 Decident 28a. ate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce 29c. License number

State Registrar

2 Registrar's Signature

			1 - State of Maryland	/ Department <i>Certificate</i>			ene 3. No. 2004	01923
	Physici		1. Decedent's Name (First, Middle, Last) Helen		Armor	2. Date of Death Month	Day Year 25 2004	3. Time of Death
	/Medic Examin Funeral Director		4a. Fecility Name (If not institution, give street and number) The John Hoplans Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last	4b, City, To Bala t birthday) If Under 1	own, or Location of Death	8. Date of Birth (Month, Dey,)	4c. County of Deeth N 9. Birth Cou	
	he Maryland 18a-f ehow otified at	ector	MO N/A BA	Fown or Location / fine { 10f. Zip C	20do	100	g. Citizen of What Cou	10d. Inside City Limits 11X Yes 2 □ No
36	72 hours after death with the Maryland natural', or items 23e or 28s-f ehow Jissal Ezamirner must be rodified at	Completed by Funeral Director	10e. Street and Number St 7 Ruffand AV &	21	ent of Hispanic Origin? (Sp fy Cuban, Mexican, Puerto		14. Race - Amer Black, White	ican Indian, , etc.
nd 21215-0036	filed within Hygiene. other then "	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last)	16a. Decedent's Usual (Give kind of work life. DO NOT use Dom (55)	a done during most of work a retired) 18. Mother's Nam	e (First, Middle, Ma	Sb. Kind of Business/li Dimistre was aiden Sumame)	ndustry
Baltimore, Maryland	1 and 2 should Health and Mer tem 27 le marke other traumatic	Tol	20a. Method of Disposition 20b. Plac	3829 Rule of Disposition (Name	(Street and Number or Run HCAS AVE 1 e of ther place)	Bultomine A Date 20	City or Town, State, Zi 10 21 3 Oc. Location - City or T	own, State
Baltir	permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service Licensee		Address of Facility BEA Careline 54			
	Physician /Medical Examiner pur price property p	Examiner	23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent or consequent	pneumo		or respiratory arres	x,	Approximate Interval Between Onset and Death I WEEK -
P.O. Box 68766	death certificate e attending phys od for use as the	Physician/Medical	d	eath 3 Ectopic pre			23d. Date of delin Month	very Day Year
	w requires that been signed I should be det	þ	Part II. Other significant conditions contributing to death but not resulting the Chronic Kidney disease, diabet	-	-	1	cco use contribute to	
al Records,	The lavate has	Completed	chanic obstructive pulmonary	disease		24a. Was an autopsy performe 1 Yes 21	prior to c	opsy findings available ompletion of cause of 2 X No
ion of Vital	Attending Physician: The ordeath. ector: Affer this certificate by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		Othor	th (Check only one) ome 5 Residen 28d. Describe how	ice 6 Other (Speci	fy)
Division	D # in E	al Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowled	edge, death occurred a	at the time, date and place,	City or Town, and due to the cau	use(s) and manner as	stated.
	To the Hospital within 24 hours of To the Funeral I completely filled	Medical	(Check only 2 Medical Examiner: On the basis of examination and manner stated. 29b. Signature and title of certifier		in my opinion, death occur License number		d. Date signed (Month	
)	4		30. Name and address of person with complying cause of death (Item 2:		RES - 000 Baltimore		January 21287	25,2004
	St Regist	ate rar	Rizwan Hoq, 600 North Wolf 31. Date filed (Month, Day, Year) JAN 2 8 2004 Segment		1	2,140	LLUT	

			1 - For State Registrar	State of Maryl	and / Depa		Health and I	Mental Hyg	iene •g. No. 20	04 01924
-	Physic /Medi	cal		PPLEFELD				2. Date of Dear	LY Day	3. Time of Death 2004 6 4 0 PM
	Examir	ner	4a. Facility Name (If not institution, gin	HOSPITAL	CENTER	KAN	. , . ,	5W14		Timore:
	Funeral Director			Sex 7. Age (In a 1	yrs last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day) AUG 4,	1'91'1	9. Birthplace (State or Foreign MD ountry)
	Maryland a-f ehow	ctor	10a. State 10b. County BALTIMO	RE E	City, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	as or 28	i Dire	10e. Street and Number 725 MT. WILSON L.	ΔNF #7Ω1		10f. Zip Code 21208			0g. Citizen of Wh	at Country?
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23s or 28s-f show or other traumatic event, the Medical Exam armusic Example of the Indiffed at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever i Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:			Hispanic Origin? (Span, Mexican, Puerto		14. Bace	American Indian, White, etc. WHITE
21215-0036	d within 72 ho giene. or than "natur It a Medical	ompleted	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) Sollege (1-4or 5+)	(Give	OO NOT use retire	during most of world	king	16b. Kind of Busi	ness/Industry
Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygene. Important: If item 27 is marked other than eny injury or other traumatic event, Ita Maone.	To Be C	17. Father's Name (First, Middle, Last	APPLEFELE			ETTA		(UNKNOWN)
	and 2 st salth and n 27 ie n		MR. MICHAEL APPLE	** *			And Number or Rui			
Baltimore,	Part and		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 3 4 ☐ Donation 5 ☐ Other (Specie	Removal from State	b. Place of Dispo	sition (Name of Pach 1720K pla 3.	_{ce)} 1/25		20c. Location - Ci BALTIMOR	ty or Town, State E, MD.
Balt	permit. Departr Importa eny inje		21. Signature of Funeral Service Lice	ansee Cathle			ess of FacilitySOL			. INC. MD. 21208
	Physician /Medical Examiner		23a. Pert1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	applications that caused the done cause on each line. a. ADENCO Due to (or as a cons	CARC)	er the mode of dyir	ng, such as cardiac		est,	Approximate Interval Between Onset and Death
760	le be executed /sicien and e burial-transit	ical Examiner	Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons						
.O. Box 68	The law requires that the death certificat ate has been signed by the attending phy bage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3 [Ectopic pregnancy Other (specify)	у		23d. Date of Month	,
rds, P	quires that n signed t uld be deta		Part II. Other significant conditions of	contributing to death but not			ren in Part I. 0158AS			ute to the cause of death?
		Completed by	PHEMONIA.					24a. Was an autopsy perform	/ pric	re autopsy findings available in to completion of cause of th?
ion of Vital	I o the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director, After this certificate occompletely filled in by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No 27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year	2 ER/Outpatien 28b. Time of Injury	28c. Injur Wor	er: 4 - Nursing Ho	th (Check only one time 5 Resider 28d, Describe ho	nce 6 Other	
Division	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, streecify)	eet, factory, office		28f. Location (Str. City or Town,	eet and Number State)	or Rural Route Number,
	Hospite 24 hours Funera etely fille	Medical C	29a. Certifier 1 Zertifying Ph (Check only one) 2 Medical Exer	nysician: To the best of my l niner: On the basis of exam and manner stated.	knowledge, death ination and/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and mann te and place, and	er as stated. I due to the cause(s)
	vithin To the compli	Me	29b. Signature and the of certifier	0.11	CIDIA .	29c. Licens	+2723	3	d. Date signed (I	Month, Day, Year) (22 2004
_	12		AVVERABALI	completed cause of death (I	item 23a) (Type, I RI 514 °		RTAWE 101 OL	of con	SPITA PRT RO	AD MD 21133
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 8 2004	32. Registrar's Sig	gnature So	acker	****			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day Month Year **Physician** Narcissis January 13, 2004 Jane Beam 5:50 PM /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner Adelphi Hillhaven Nursing Home Prince George's if Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐XF 251-34-0617 76 Yrs Director Dec 30, 1927 South Carolina Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylend nant of Heatth end Mantal Hygiena int: If Nem 27 is marked other than "natural", or items 23s or 28s-1 show 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location items 23a or 28a-f showing must be notified at 1X Yes 2 □ No Prince George's Adelphi MD Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20783 3121 Powder Mill Road USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Merital Status Black, White, etc. 1 ☐ Yes 2 🔀 No 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify. Ş 3 Widowed 4 Divorced Yeer or Dates: White Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mamie Belue Robert Parker ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 3121 Powder MI11 Road Adelphi, MD 20783 Alfred Beam Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If It any Injury or one 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Landrum, SC Oak Grove Bapt. Ch. Cem. 1-17-04 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Petty Funeral Home 124 N. Trade Street Landrum, SC Part | Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical isease - End Stage Examiner Due to (or as a consequence of) Examiner buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Lue to (or as a consequence of). Division of Vital Records, P.O. Box 6876 Be Completed by Physician/Medical or Attending Physician: The law requires that the death certificate ba Due to (or as a consequence of): for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 🗆 Yes 2X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Medicai Certification: To 1 Yes 2 No this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending s aftar death. 1 ☐ Yes 2 ☐ No 2 Accident investigetion 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital of within 24 hours a To the Funeral Dicompletaly filled it 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Yeer) January 20, 2004 D0053337 30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print) Dorothy Seay, M.D. 10801 Lockwood Dr., Silver Spring, MD 20901 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State

DHMH 16 Rev 6/95

Registrar

JAN 2 8 2004

			For State Registrar	• •	aryland / Dep	artment of Health and M rtificate of Death	•	ene 2001	+ 01926
			Decedent's Name (First, Middle, Last,)			2. Date of Death		3. Time of Death
	Physici	an	Muriel B.		atty		Month January	26 2004	9:15 PM
5	/Medic		4a. Fecility Name (If not institution, give			4b. City, Town, or Location of Death	ouridar y	4c. County of Deatl	9.10 1
20	Examin	er	816 Riverside Dr			Pasadena		Anne A	
					e (In yrs. last birthday)		8. Date of Birth	Q Rint	
	Funeral Director		213-76-0610	M 2√F /. A9	86 Yrs.	Months Days Hours Min.	April 10	1917	nplace (State or Foreign untry) MD
pu	3		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	ocation			10d. Inside City Limits
aryle	o a	7		I o b out	,				1 ☐ Yes 2 ☑ No
ē.	8a-f	ctc	Maryland Anne A	under	<u> </u>	Pasadena	1.40	0	
if t	or 2	Dire	10e. Street and Number			10f. Zip Code	109	. Citizen of What Co	untry r
ath v	238	Funeral Director	816 Riverside Dri			21122		USA_	· · · · · · · · · · · · · · ·
r de	E 5	ne	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spot Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
afte afte	a E	F	1 ☐ Never Married 2 X Married	1 ☐ Yes 2 ☑ I If Yes, Give	No	1 ☐ Yes 2 ☒ No Specify:		Specify:	White
003	2 2	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:					
Maryland 21215-0036 nd 2 should be filed within 72 hours after death with the Maryland	natu	Completed	15. Decedent's Edu (Specify only highest grad		16a. Dece (Give	dent's Usual Occupation a kind of work done during most of work DO NOT use retired)	ing 16	b. Kind of Business/l	ndustry
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d 21	Hygier ther th	Sor	12			Homemaker		Househo]	d
	d off	Be	17. Father's Name (First, Middle, Last)				(First, Middle, Ma.		
E B	Ment	ပ	Clarence P.	Harrisor		Virginia		Blair	
laryia 2 should	and s		19a. Informant's Name/Relationship (T)			ing Address (Street and Number or Rura			ip Code)
	lealth m 27 I her tra		Robert E. Beatty	(spouse)	816	Riverside Drive, F	asadena,	MD 21122	
	Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show yinjury or other traumatic event, the Madical Examiner making notified at once.		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place) Jan.	²⁰⁰ 31	c. Location - City or	Town, State
Pages	ent o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State		l l		en Burnie	. Maryland
	ortar injui		21. Signature of Funeral Se vice License			2. Name and Address of Facility			1 Home, P.A
Balt permit.	Depa Impo any ir		1 Hud. &	2	3	3111 Mountain Road,		-	
0			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that dauser					Approximate
2 /			shock, or heart failure. List only o Immediate Cause (Final	ne cause on each li	ine.				Interval Between Onset and Death
	ysician		disease or condition resulting in death)	a. Conges	etine of	earl failing			X one year
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/g	Sit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	A CA	a consequence on.	-Car 3/1 - S an			Y 2018000
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16 by 68	rsician and e burial-transit			Doe to (or as	a consequence on).				
ate b	S C	licai		J					
c 68	ed by the attending phy detached for use as the	Completed by Physician/Media	IF FEMALE:						
Box eath cert	tend r us	an/	23b. Was decedent pregnant		2 Fetal death 3	□Ectopic pregnancy		23d. Date of deli	very Day Year
Ges des	ed fo	sici	in the past 12 ntonths? 1 ☐ Yes 2 X No	4□Pregnant at 9□Unknown	t time of death 5[Other (specify)		, and the	Day 100.
P.O.	by the	h	9 Unknows	020111101111					
es th	signed l d be det	by F	Part II. Other significant conditions co	tributing to death b	out not resulting in the u	inderlying cause given in Part I.	1	co use contribute to	
D in	should I	ed	- Halabiarp	7m	emares	ne	Yes	2 No 3 Pro	bably 4 Unknown
0 %	s been shouk	olet	- Sincell An	nel 1	neseeta	\sim	24a. Was an	24b. Were au	opsy findings available ompletion of cause of
Re se	e ha	m					autopsy		
<u>a</u> :	ificat or. pë	e C	25. Was case referred to medical			26 Place of Death	1 Yes 2 X	INO ILLIES	2 NO
Vital Record sician: The law requir	cert	8	examiner? . C	Hospital:	ent 2 ER/Outpatie	Other	1	e 6 □Other (Spec	76.1
o f	r this rald	. To	27. Mapner of Death	28a. Date of Inju	ry 28b. Time o	of 28c. injury at	28d. Pescribe how		ny/
D dia	After fune	ion	1 Natural 5 ☐ Pending	(Month, Da	y Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
Division of a or Attending Phy	deatl	ica	3 ☐ Suicide 6 ☐ Could not be	28e Place of Ini	jury - At home, farm, st		28f Location (Stree	nt and Number or Ru	ral Route Number.
S S	after Dire	Certification:	4 Homicide determined	building, et	c. (Specify)	, soci, radioty, onioc	City or Town, S		
pital	eral illed		29a. Certifier 1X Certifying Phy	sision. To the best	of mu knowledge, deat	th conversed at the time, date and place	and due to the save	o(s) and manner as	atatad
Division of Vital Records, P.O. Box 68769. To the Hospital or Attending Physician: The law requires that the death certificate by exe	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical		ner: On the basis o	f examination and/or in	th occurred at the time, date and place, evestigation, in my opinion, death occurr			
ŧ.	within 2 To the complet	Mec	29b. Signature and title of certifier	and manner sta	ated.	29c. License number	29d	Date signed (Month	Day Yearl
P	.¥ 5 8	_	255. Gigrators and time of Certifier	Λ 1	10	1002001)	01/27/	ail
	F		Sherrin	1. F	anely	(P) 100 78,76.	6	V1/ a //	U4
	10		30. Name and address of person who co	mpleted cause of d	death (Item 23a) (Type,	Print) 1845 DOKWO	od Ros	& she	te 307
	Y		Ur- Salvagion	1. Fam	- 1 vez	alen Burn	w pla	9 210bi	· ·
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 8 2	- 4	rar's Signature	hoard !			
	negisti	वा ।	UMINA O A	UUT PAS	, -	KARI COLORUZI			

			State of Maryland / D				ene	0100
			1- State Registrar	Certificate of L	Death	Reg	No. 2004	01927
п	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	/Medic		BARBARA JEANNE BRESENHAN			JANUARY	24, 200	
(E)	Examir	ier	4a. Facility Name (If not institution, give street and number)		r Location of Death		4c. County of Deet	
4/4	Tunnel	※	706 BROADVIEW BOULEVARD 5. Social Security Number 6. Sex 7. Age (In yrs. last birtle)	GLEN BUF		8. Date of Birth	ANNE ARUI	
	Funeral Director		10 H 200 5 72	Yrs. Months Days	Hours Min.	(Month, Day, Y	1931 WEST	nplace (State or Foreign untry) VTRCTNTA
As	D		Usual Residence of Decedent			PHO: 25,	TOOT WIND!	
	arylar	_	10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits 1 ☐ Yes 2 📉 No
	he M	ecto		BURNIE			011 (141)	
	a or	Funeral Director	10e. Street and Number 706 BROADVIEW BOULEVARD	10f. Zip Code 21061		-	Citizen of What Co	
	feath	era	11. Marital Status 12. Was Decedent Ever in U.S.		ispanic Origin? (Sp.		NITED STAT	
ထ	after c	ᆵ	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No	13. Was Decedent of Hi If Yes, specify Cuba		Rican, etc.)	Black, White	e, etc.
03	raf', c	1 by	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2X No	Specify:		Specify:	WHITE
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or itema 23a or 28a-f ahow he Madigal Examilian interal be invitible a	Completed by	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	ation during most of work	ing 16	b. Kind of Business/I	ndustry
12	within ane. then	E E	Elementary/Secondary (0-12) College (1-4or 5+)	HOMEMAKER	i)		OWN I	HOME
	Hygie Hygie Sther		17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle, Ma	iden Sumame)	
lan	id be ental ked o	To Be	JAMÉS B. BROGAN		ALICE G		,	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Haalth and Mental Hygiene. Importants if item 27 is marked other than "natural", or itema 23s or 28s-f ahow appringury or other traumatic avent, the Madical Examinating the mailing at ADGS.	-	19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street a	and Number or Rura	al Route Number, C	ity or Town, State, Z	ip Code)
	and 2 saith a n 27 is		The state of the s	6 BROADVIEW			URNIE, MAI	RYLAND 21061
ore	of Holling		20a. Method of Disposition 20b. Place of commetery 20b. Place of commetery	Disposition (Name of y, crematory or other place	JANU		c. Location - City or 1	
Ē	. Pages tment of tant: If it jury or o		' 4 □ Denation 5 □ Other (Specify) MEADOWE	RIDGE MEM. P	2K.		KRIDGE, MA	
Baltimore,	permit. Page Department Important: It any injury o		21. Signatur Them Service Utensee	22. Name and Addres KIRKLEY-RUD 421 CRAIN	ss of Facility DICK,EUNI	ERAL HOME	P.A.	21061
			23a. Part1. Emer the disease, or complications that caused the death. Do no					ARY LAND Approximate
	Dharatatan		shock, or heart failure. List only one cause on each line.	'	Interval Between Onset and Death			
	Physician // / / / / / / / / / / / / / / / / /		disease or condition resulting in death) Due to (or as a sersequence of the condition of t	mers I	1500			years
	Examiner			.,,				U
350	D #	ner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	A).				
	ecute and trans	Examiner	that initiated events c.					
760,	ate be executed nysician and he burial-transit	cai E	Due to (or as a consequence of	1):				
687	phys phys s the	edica	d					
X	nding use a	NM√	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	_			23d. Date of deliv	/erv
m.	death e atte	icia	in the past 12 months? 1 Yes 2 D No. 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
Ö	at the by th tache	by Physician/M	9 ☐ Unknown					
Vital Records, P.O. Box	w requires that the death certifica been signed by the attending ph should be detached for use as th	by F	Part II. Other significant conditions contributing to death but not resulting in				co use contribute to	
ord	requii een s nould	ted	can vacines of ace	extremit	167	1 🗆 Yes	2 No 3 □ Pro	bably 4 Unknown
Sec.	2 3 2	Completed	cysphagia			24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
<u>a</u>	n: Th ficate r, pag						l2 death? No 1 ☐ Yes	2 No
	sician: The law s certificate has b lirector, page 2 si	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	patient 3 DOA		Check on one	- a Flow (a	
ō	Attending Physician: The law requires that the death certifica or death. sctor: Aler this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the funeral director.	-	27. Manner of Seath 28a. Date of Injury 28b. Ti	ime of 28c. Injury	at :	28d. Jescribe how i	e 6 Other (Specinjury occurred	ity)
ion	ath. rr: After ne funer	atio	2 Accident investigation	njury Work M 1 ☐ Y	<br Yes 2 □ No			
Division of	i or Attendater death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farr building, etc. (Specify)	m, street, factory, office		28f. Location (Stree City or Town, S	t and Number or Rur	al Route Number,
Ω	ospital o hours af uneral D ly filled ir							
	To the Hospital or Attending Physician: The within 24 broads after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier Check only one) Certifying Physician: To the best of my knowledge, (Check only one) and manner stated.	death occurred at the tim For investigation, in my or	ne, date and place, a pinion, death occurr	and due to the caus ed at the time, date	e(s) and manner as a and place, and due t	stated. to the cause(s)
	To the H within 24 To the Fi complete	Me	29b. Signature and title of certifier	29c. License	number	29d.	Date signed (Month,	Day, Year)
À.	->-0		xuno	1	29145	5	1-26	-GU
7	"IS		3 Name and address of person who completed cause of death (Item 23a) (T	Type, Print	11.1	*	4 Mil	en willo MD
	1		Selection Con Con MD 860 31. Date filed (Month, Day, Year) 32. Registrar's Signature	verterans	Mahm	Ty Too	1	21100
A.	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 8 2004 32. Registrar's Signature	& Louis	20	J		

DHMH 17 Rev 1/2001

Registrar

JAN 2 8 2004

Physici /Medi Examir **Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at

	Plea	se Type or	Print in R	lack In	delibl	e Ink	Δεςι	ıre Δi	l Conie	s Are I ec	nible		
	rice		of Marylan								JIDIC.		
Δη	end Item 5 per FH,G		•				Death			Reg. No. 2	101.	0103	n
I	Decedent's Name (First, Middle		Taile						2. Date of I	Death	J U 4	3. Time of Death	Ļ
an al	Clara			_			nds		Month JANUA		2004		N
er	4a Fecility Neme (If not institution		ımber)				46. Сіtу, 16 Ва 1 t		ocation of De	ath 4c. Cour	ity of Death		
	St. Agnes Ho					1 1 1/2 2 2	141						
	5_Social Security Number 231-50-1881	6. Sex 1 ☐ M X [X]F	7. Age (In yrs. I		Months	Pr 1 Year Days	If Under Hours	Min.	8. Date of E (Month, I	Birth Day, Year)	9. Birth	place <i>(State or Forei</i> nt <i>ry)</i>	gn
	231-51-1881	-	73_	Yrs.					11]	2 30	N	C	
	Usuel Residence of Decedent 10a. Stete 10b. County		10c City	, Town or Lo	cation							10d. Inside City Limit	ts
tor	MD NA			ltimo								1 X iYes 2□N	
5	10e. Street end Number				10f. Zi	ip Code				10g. Citizen o	f What Cou	ntry?	
	315 Martingal	0 7170				21	229			IJ.	S.A.		
era	11. Marital Status		edent Ever in U,	S. 13. V	Was Dece			gin? (Sp	ecify Yes or I		ace - Ameri	can Indian,	
Ē	1 ☐ Never Married 2 ☐ Marr	Armed F ried 1 ☐ Yes			1.21				Rican, etc.)	В	lack, White	, etc.	
þ	3 ₩idowed 4 Divorced	If Yes, G Year or	2 No ive Dates:		1 🗆 Yes	XXNo	Specify:			Spec	eify: E	lack	
8	15. Deceden	t's Education		16a. Deced	dent's Usu	uaf Occup	ation			16b. Kind of	Business/Ir	ndustry	
Siet	(Specify only highes	st grede completed		16a. Deced (Give life. L	kind of w DO NOT t	ork done use retire	during mos d)	t of work	ing				
Be Compieted by Funeral Director	Elementary/Secondary (0-12)	na	(1-4or 5+)	Но	usew	vife				Н	ome		
Ŏ	17. Father's Neme (First, Middle,	Last)					18. Mothe	er's Name	e (First, Midd	le, Maiden Sum	ame)		
To B	Jessie Lucas						Ann	ie E	Pittma	an			
-	19a. Informant's Name/Relations			19b. Mailir	ng Addres	ss (Street	and Numbe	er or Run	al Route Num	ber, City or Tow	m, Stete, Zi	p Code)	_
			0.10							own, Mo		133	
	Cresel Moore 20a. Method of Disposition	e-Daugnt	20b. PI	ace of Dispo	sition (Na	ame of		ande	Date	20c. Location			
	1 Surial 2 Cremation		State	metery, cren	-	-	-		107/	1 .		- t	٦.
	4 Donation 5 Other (S		Kıı				Park ss of Facilit		1/2//)4 Rand	alls	stown, Mo	a —
	21. Signature of Funeral Service	ticensee	R.	M	arch	ı F/	H We	st	Balt	imore	Md	21215	
	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the death	. Do not ent	er the mo	de of dyir	ng, such es	cardiac (or respiratory	arrest,	1	Approximate Interval Between	
	SHOOK, OF HOUR TURIOUS. LIST	drifty one deduce on	ouori inio.								i i	Onset and Death	
	Immediate Cause (Final disease or condition	DUI	MANARY	1170	150	740	164	All	ATERA	1 i	1	7 11100	
	resulting in death)	a. 7-VIC	MONARY Due to (or	as a conseq	uence of):	13 ' '	0(5)	INE	KTRAI	ES	z WAJ	_
ner			MONAK) MONTH.	_
amlne	Sequentially list conditions,	b. 1 46		as a conseq			200				1	/ 1941 17	2_
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cia	5 60			M			i- D1		an Di	d 4abaaaa		to the cause of deat	h2
ıys	Pert II. Other significant condition	ons contributing to t	leath but not resu	iting in the ui	nderlying	cause giv	en in Parti			1		obably 4 ☐ Unkno	
효	CHRONIC	OBSTR	UCTIVE	= PUL	MOI	NAR	Y DL	SEAS	Z= 1L]Yes 2₽NG	3 ⊔ Pro	boably 4 Unkno	PWII
ð										s en eutopsy	24b. W	ere autopsy findings	s
et et	CIRRHO.	515							per	formed?	av	vailable prior to empletion of cause	
gr									24	_	of	déath?	
Be Completed by Physician/Medical									16	Yus 2LINo	1	Tves 2□ No	
Be	25. Was case referred to medica examiner?			-		Lou		of Deat	h <i>(Check onl</i>)	r one)		\	
2	1 ☐ Yes 2 ☐ M		-	ER/Outpatien			4 🗆 Nu			sidence 6 🗆 C		fy)	
ation:	27. Manner of Deeth 1 ☐ Naturel 5 ☐ Pendin	28a. Date (Moi	of Injury oth, Day Year)	28b. Time of Injury		28c. fnjur Wor			28d. Describ	e how injury occ	urred		
aţ	2 ☐ Accident investi				М	10	Yes 2□	No					

within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit Medical Certifica

To the Hospital or Attending Physician: The law requiras that the death cartificate be executed Division of Vital Records, P.O. Box 68760,

CLARA BONDS

Physician /Medical Examiner

Baltimore, Maryland 21215-0020

6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Siç	nature and	I title of	certifie	
	U	- ~	7	13

Certifying Phyelcfan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted.

2 Wedical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title or certainer

29b. Signature and title or certainer

20c. Annuary = 30c. Tanuary = 30c ST. AGNES HEALTH CARE 900 CATON

31. Date filed (Month, Carrel) 8 2004 32. Registrar's Signature

State Registrar

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State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month JAN. Year John Thornton Berger 2004 21, 12:15 PM /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 706 S.BAYLIS STREET BALTIMORE CITY N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month. Day, Year) | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North Ones | North 5. Social Security Number 6. Sex rEM 2□ F 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Director 215-30-8214 68 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location ral, or Itams 23a or 28a-f ehow Examiner must be notified at 10d. Inside City Limits Director Maryland Yes 2□No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 706 S Baylis Street 21224 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Be Completed by Specify White 3 ☐ Widowed 4 ☑ Divorced "netural" the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 yrs College (1-4or 5+) Welder Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert M. Berger Helen M. Thornton 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 809 W. 38th Street Baltimore, Maryland 21211 19a. Informant's Name/Relationship (Type, Print) Sandie Castle/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X2Cremation 3 ☐ Removal from State permit. Page Department of Important: If ony injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 1/23/2004 Towson, Maryland 21. Signature of Funeral Service Licensee Midd-Ruck Funeral Home of Dundalk, Inc dance 7922 wise Avenue, Dundalk, Maryland 21222 23a. Part1. Enter he disease, or complications that caused the deat shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** atherescherotic disease or condition resulting in death) Cardinascular disesse /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death Day Year 5 Other (specify) 1 Yes 2 No 9□ Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy _performed* 1 XYes 2 No 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Certification: To XXYes 2 No 4 Nursing Home 5 Residence 6 Nother (Specify) AT SCENE funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of After 28d. Describe how injury occurred 1 XNatural 5 Pending investigation Injury 1 Yes 2 No 2 Accident Director: 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

XXMedicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signatore and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E JAN. 22, 2004 w Name and address of person who completed car of death (Item 23a) (Type, Print) SINK111 Penn Street, Baltimore, Maryland 21201 IA ic MON: CA-31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 2 8 2004 Registrar

		-	For State Registrar	State of Maryland			of Health of Death			giene Reg. No. 2	004	01932	
ı	Physicia	an	Decedent's Name (First, Middle, Las Jeanette Loui se	dent's Name (First, Middle, Last)					2. Date of Death Month Day Year JANUARY 23, 2004 4:50 F ^M				
7	/Medic Examin		4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center Tows						4c. County of Death				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.										
	Director		212-12-1876 1 Usual Residence of Decedent	2-12-1876 10 M 2 X F 83 Yrs. April 11, 1920 Maryland									
	show ad at	5	10a. State 10b. County Maryland Baltir		, Town or Loca len Arm	ation						10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	th the N or 28a-f	Directo	10e. Street and Number 10f. Zip Code							10g. Citizen	of What Co		
030	be lied within 72 nouts after death with the Maryland tall Hygiene. Ad other then "natural", or iteme 23a or 28a-f show event, the Medical Examinating must be notified at	Fral	11541 Long Green Pike 2105 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent								USA 14. Race - American Indian,		
		by Funeral	1 Never Married 2 Married 1 Yes 2 No 11 Yes 2 No 11 Yes 2 Warried 1 Yes Giv A Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or I If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:				Black, White, etc. Specify: White			
9500-61212	n 72 ho "natur eulical	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)						ng	16b. Kind of Business/Industry			
		Comp	Elementary/Secondary (0-12)	College (1-4or 5+)	Inte	rnal A	uditor					Blue Shield	
ylan		To Be	George Washington Heise Eva J. Dy						le (First, Middle, Maiden Surname) KE ral Route Number, City or Town, State, Zip Code)				
Mar	12 d 12 d 12 d 12 d 12 d 12 d 12 d 12 d		19a. Informant's Name/Relationship (Bruce A. Emmel/Son	Type, Print)			ia Court					ap Code)	
Baltimore,	of Hill of Hill roth		20a. Method of Disposition 1 ☑ ABurial 2 ☐ Cremation 3 ☐	Bomoval from State	ace of Disposi	atory or oth	e of her place))ate	20c. Locatio	-		
	permit. Peg Department Important: I any injury o		*4 □ Donation 5 □ Other (Specification 21. Signatore of Funeral Service Licer	·	wood Cema	Name and	Address of Faci	1/28,	5305 Hav			ary1and	
eg —	Den imp		Chiestina of Hilton Baltimore Maryland 21214										
di.	4 8 A		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirat shock, or heart failure. List only one cause on each line. Immediate Cause (Final						or respiratory ai	rrest,		Approximate Interval Between Onset and Death	
r.	Physician /Medical Examiner		disease or condition resulting in death)	a. SEPSIS Due to (or as a consequence of):									
	icate be executed physician and s the burial-transit	er	Sequentially list conditions, if any, leading to immediate	b. ADVANCED INTERSTITIAL LUNG DISEASE Due to (or as a consequence of):									
A A		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. CLOSTRIDIUM DIFFICILLE COLITIS Due to (or as a consequence of):									
68760	e ys	dical	•	d									
P.O. Box	death certif a attending ad for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)						23d. Date of delivery Month Day Year			
	uires that the de signed by tha a ld be detached t	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
Records,	To the Hospitel or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by th completely tilled in by the funeral director, page 2 should be detached.	Completed							autor	24a. Was an autopsy autopsy findings available prior to completion of cause of death? 1 9 c 20 No 1 9 Yes 20 No			
on of Vital		Be								ath (Check only one)			
		ion: To	1 Yes 2 No 27. Mapner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? Work?					ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				
Division		Certification;	2(Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined 128e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
)	To th within To th compl		29b. Signature and title of certifies Mehter M. D. Signature and title of certifies Ordered 1 4 4 50							January 23kd, 2014.			
•	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								1 20	1 2004.	
	10		JOGINDER F. M 31. Date filed (Month, Day, Year)	EHTA, M. I).	7601 (ISLE	R DRIVE	= TO	JSON.	MARYL	AND.	212714	
\$	Sta Regist			2 8 2004		da	ace B						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day William Laverne Bennett 6:55 PM January 23,2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Riverview Nursing Center

Baltimore, Maryland 21215-0020

Physician

/Medical

Examiner

Fune Direc

Physici

ביייי בייייי בייייי בייייי בייייי ביייייי	To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	
within 24 hours after death.	To the Funeral Directo	completely filled in by the	
	1	1	

Division of Vital Records, P.O. Box 68760,

		TITTOT VICE HOLDI	9 0000-				LOSCA		100	remote co.	
eral		5. Social Security Number		Age (In yrs. last b		Under 1 Year onths Days	If Under 24 H Hours M	rs. 8. Date of E	lirth Day, Year)	9. Birthplace (State or Country)	Foreign
tor		218-01-3728	1 / M 2□ F	87	Yrs.	Days	riodis Wi	Jan.	24,1916	Maryland	
		Usual Residence of Decedent									
	_	10a. State 10b. County		10c. City, To	wn or Locatio	n				10d. Inside City	/ Limits
	Director	Maryland	Baltimore				H	Essex		1 ☐ Yes 2	2∰No
2	ire	10e. Street and Number			10	of. Zip Code			10g. Citizen of	What Country?	
		902 Virginia	Avenue				21221			States	
	Funerai	11. Marital Status	12. Was Deceder	nt Ever in U.S.	13. Was I	Decedent of H	ispanic Origin?	(Specify Yes or N		ce - American Indian,	
2	ᆵ	1 ☐ Never Married 2 ☐ Marri	Armed Force	s?	If Yes	, specify Cub	an, Mexican, Pue	erto Rican, etc.)		ck, White, etc.	
9	by	3⊠ Widowed 4 □ Divorced	If Yes, Give Year or Dates		1 □ Y	es 2√2 No	Specify:		Specif	Y:	
		15. Decedent		AAAATT						White	
	Completed	(Specify only highes	t grade completed)	108	a. Decedent's (Give kind	of work done	during most of w	rorking	16b. Kind of B	usiness/Industry	
	Ē	Elementary/Secondary (0-12)	College (1-4o			OT use retired	•				
	ပိ	47 Fathada Nama (First Adidd)	2 Years	5	Airc	raft M	echanic			ns Aerospac	e
	Be	17. Father's Name (First, Middle, I	asi)				18. Mother's N	ame (First, Middle	e, Maiden Suman	ne)	
	ို	William L. Be	nnett				F.	lorence	Harrison		
		19a. Informant's Name/Relationsh	ip (Type, Print)	19	b. Mailing Ad	dress (Street	and Number or F	Rural Route Numi	ber, City or Town,	State, Zip Code)	
		Ms. Cathy Ben	nett(Daught	er)	902 V	irgini	a Ave.	Essex,	Maryland	21221	
	- 9	20a. Method of Disposition	_		of Disposition ery, crematory		0)	Date	20c. Location -	City or Town, State	
		tt⊡tBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		е	_			2004	Dol+:	marca Marani	
	- 4	21. Signature Funeral Service L		Palk	wood C	ne and Addres		2004	Balti	more, Maryl	and
ouce.		H GIGINIO E		(/	Dud	a-Ruck	Funera:	l Home o	f Dundal	k, Inc.	
		C/ Bodon	C/Ce	c	792	2 Wise	Ave. I	Dundalk,	Marylan	d 21222	
8		23a. Part 1. Enter the disease, or shock, or heart ailure. List of	omplications that cause	ed the death. Do	not enter the	mode of dyin	g, such as cardia	ac or respiratory a	arrest,	Approximate	
an			O 4	Λ.						Interval Betwee	
al		Immediate Cause (Final disease or condition	Mal	elle	acu	Ve_ 1	14000	in dial	inforce	han 2-31	VS
er		resulting in death)	a	Due to for an a		,	100		_//		
4	<u>ē</u>		(. H	May	consequence		D	21000	V	un-kn	own
	ੋਂ ਵ		- b. Lac			,	80.				
	ξ.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or as a	consequence	of):					
	<u> </u>	Cause (Disease or injury	c								
	₩	that initiated events resulting in death) Last		Due to (or as a	consequence	of):			***		
	ž		d.								
	rnysician/Medical Examiner										
	3	Part II. Other significant condition	s contributing to death	but not resulting in	n the underlyi	ng cause give	n in Part I.	23b. Did	tobacco usa con	tribute to tha causa of d	death?
å	£	Alahou	10H2	Demo	unti a	,	HTAL	1 🗆	Yes 2 No	3 □ Probably 4 ☑ Úni	known
1	<u> </u>	7,5,7,00	100				()),				
3	<u> </u>	Clattonic	aki	01 7	flori	1121	ian.		en autopsy	24b. Were autopsy find	lings
3		CNOCHOL	2 9010		7000	- W	1001	репо	ormed?	available prior to completion of caus	se
	rompier									of death?	
١	3	25. Was case referred to medical							Yes 2 No	1 ☐ Yes 2 ☐ No	1
å	Ď	examiner?	Hospital:			Otho	_	ath (Check only o			
F	-	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Li Inpati			DOA Othe	412 Nursing F		dence 6 □Othe		
3	5 '	1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ary Yea <i>r)</i> 28b. 1	Fime of njury	28c. Injury Work	at ?	28d. Describe	how injury occurre	ed	
1	5	2 Accident investiga			М	1 🗆 Y	es 2□No				
1		3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	△A ∠oe. Place of in	jury - At home, fa tc. <i>(Specify)</i>	rm, street, fac	ctory, office		28f. Location (S City or Tox	Street and Number	r or Rural Route Number,	;
ق ا	5		g, o	io. (opcony)				Oily of 707	vii, State)		
9	<u>ē</u>	29a. Certifier 1 Cartifying	Physician: To the best	of my knowledge	, death occur	red et the time	, date and place	e, end due to the	cause(s) and mar	ner es stated.	
Medical Certification:		(Check only 2 ☐ Madical Ex	taminer: On the basis of and manner st	i examination and	d/or investiga	tion, in my opi	nion, death occu	irred at the time,	date and place, e	nd due to the cause(s)	
2	1	29b. Signature and title of certifier				29c. License	number		29d. Date signed	(Month, Day, Year)	
		Affaire	M.D			7) -	387		-		
	-	1111					/.	- 1	- 1 -	1-2004	
	3	30. Name and address of person wh	1	leath (Item 23a) (Type, Print)		al AL	117	MD-	21221	
_		7	BEAM.	709-	C/15	ICK	N BL	V ~	·· U	-12-1	
tate		31. Date filed (Month, Day, Year)		ar's Signature	100						
strar		77116 10 0 2	Jak Rech	an Ast	Book						
5/95					-						

Registrar

			Flease	• •		artment of Health and		_	
			for State Registrar	State of Marytan		rtificate of Death		Reg. No. 200	6 01931
			1. Decedent's Name (First, Middle, La	ist)			2. Date of Dea Month	ath	3. Time of Death
	Physicia /Medic		Charles 1	Barner Jr.			JANUAR		+ 0752 AM
2	Examin		4a. Fecility Name (If not institution, gir	11		4b. City, Town, or Location of Do		4c. County of Dea	th +
			SAINT HONES	HEALTHCAR	1=	BALTIMORE If Under 1 Year If Under 24 H		70//	thplace (State or Foreign
	Funeral Director		246-24-4996	Sex 7. Age (In yrs	76 Yrs.		fin. 8. Date of Birt (Month, Day 5 < p + 2	y, Year) Co	H. Chaling
	and		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or L	ocation	•		10d. Inside Oity Limits
	Maryl a-f eho	tor	Maryland H	IA		Bultimore			1 √Yes 2 No
	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 is marked other than "natural", or Items 23s or 28s-f ehow traumatic event, the Mudical Examiner must be motified at	Funeral Director	10e. Street and Number H15 Rokeley	Rd.		10f. Zip Code 2/229		10g. Citizen of What Co	ountry?
	death	ner	11. Marital Status	12. Was Decedent Ever in I Armed Forces?	J.S. 13.	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Po	(Specify Yes or No-	14. Race - Ame Black, Whit	
920	ours after al', or Ite		1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:		1 □ Yes 2 □ No Specity:	,	Specify: 6	lack_
5-0	72 ho	eted	15. Decedent's E (Specify only highest gr	ducation rade completed)	16a. Dece	dent's Usual Occupation skind of work done during most of	working	16b. Kind of Business	Industry
21215-0036	within ene. then "	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	Engineer		City of	Baltimore
d 2	Hygin other	0	17. Father's Name (First, Middle, Las	1)		18. Mother's	Name (First, Middle,	Maiden Sumame)	
ılan	uld be Menta irked itic ev	To B	unknown			urk	lown		
Maryland	2 sho and h	·	19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Street and Number of	17 11:	or, City or Town, State,	Zip Code)
	1 and 1ealth em 27 ther ti		20a. Method of Disposition	20b.	Place of Disp	osition (Name of	1301 Mare Date	20c. Location - City or	Town. State
Baltimore,	ages 1 an nt of Heali t: If item 2 f or other		1 Burial 2 Cremation 3	Removal from State	cemetery, cre	matory or other place)	1/29/04	Dalin Nile	Mordand
Ē	permit. Pa Departmen Important: any njury		* 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		irrison	2. Name and Address of Facility [Ker Cha	vis & Crond	te F.S. F.A.
Ba	Departition Depart		1 Kevin	farker	3	512 Frederick A	R. Baltin	nere', Mary	land 2/229
			23a. Pert1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the dea y one cause on each line.	ith. Do not en	iter the mode of dying, such as care	diac or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. ASPIRATI	NO	PNEUMONIA			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):		v= 0	P.	1 wales
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	quence of):	THAT STAPHYLOG	occus nur	FUS TREUTION	TI WEEK
	uted d ansit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	CHRINIC OF	STRUC	TIME PULMONA	RY DIXE	SE	one UPAR
oʻ	be executed Sicien and burial-fransit	Examl	resulting in death) Last	Due to (or as a conse		· · · · · · · ·	42		1)
8760	ate be ex hysicien the burial	llcal	,	La CHRONIC 1	(RSP11	GTORY MILLY	T.		ous worth
89 x	death certificate I e attending physion for use as the t	Physiclan/Medl	IF FEMALE:	23c. If yes, outcome of pregr	nancy			23d. Date of de	ivery
Вох	eath atten	clan	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	al death 3	□Ectopic pregnancy □ Other (specify)		Month	Day Year
P.O.	that the de led by the a detached t	hysi	9 Unknown	9 Unknown					
	96	þ	Part II. Other significant conditions	contributing to death but not re	-	underlying cause given in Part I.		obacco use contribute to res 2 □ No 3 □ Pt	the cause of death?
COL	w require been si should l	lete	OPPLEASED I		EASE		24a. Was	an 24b. Were at	utopsy findings available completion of cause of
Division of Vital Records,	0 - 0	Completed	- I ded like A	HOCONETT FIL	1-13.	<u> </u>		rmed? death?	completion of cause of
ita	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?			26. Place of	Death (Check only o		
× ×	S : B	은	1 ☐ Yes 2 X No	Hospital: 1 Inpatient 2	1	The state of the s		dence 6 Other (Spe	cify)
on c	ding P	lon:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe h	now injury occurred	
isic	or Attending after death. Director: After in by the fune	ficat	2 Accident investigate 3 Suicide 6 Could not determine	be 28e. Place of Injury - At I	home, farm, st			Street and Number or Ri	ural Route Number,
ō	el or A s after al Dire	Certification:	4 Homicide determined	building, etc. (Spec	ify)		City or Tow	m, State)	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical (th occurred at the time, date and pl nvestigation, in my opinion, death o			
	To the within To the compl	Me	29b. Signature and title of certifie	20 MO natrolow	to Dave	29c. License number		29d. Date signed (Mont	h, Day, Year)
)			Alexander Soll	ATTERIOR	ICHT DE	D	0041711	JANUARY :	23, 2004
	12		30. Name and address of person who	completed cause of death (Ite		14.1	- 0-		, , , , , , , ,
1.0	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	WILKE	ns I Phe Suite	- CG D:	IM CE 11.4.	21229
	Registr		JAN 2 8			Sportal			

State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year TESSE H. BENSON ANUARY 2004 /Medical 8:00 P 4a. Facility Name (If not institution, give street and number) 4c. County of Oeath Examiner 4b. City, Town, or Location of Death HARBOR HOSPITAL CENIER 3001 SHANNOVER ST BALTIMORE BACTIMORE 8. Date of Birth (Month, Day, Year) Aug. 14, 1933 If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1**X**0 M 2□ F Hours West Virginia 219 30 2962 70 Director Usual Residence of Decedent Show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heatih and Mantal Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatte event, the Medical Examinating to a citized at N/A 1X Yes 2 □ No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 W. Talbot Street 21225 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) llth Police Officer Balto. City Police Dept. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jesse Benson Sr. Virginia Wratchford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Benson wife 20 West Talbot Street Baltimore, Maryland 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery 1/24/2004 Baltimore, Maryland 22. Name and Address of Facility
George J. Gonce Funeral Home, P.A. 21. Signature of Funeral Service License anna rameroush 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner hoyus neumon Sequentially list conditions, if any, leading to immediate the first line that Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed burial-transit Emphysem and Due to (or as a consequence of): Box 68760. the attending physician hed for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.0. detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? Records. þ be 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No Division of Vital 1 Tyes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3□ DOA this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Understigning Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUDIVARAH HARBORIOSPITAL CENTER, 3001 HANNOVER ST 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 01936 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) Month Yeer **Physician** BAKER 4:45 PM TUNE Jan 20 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BA LTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2**X**F 214 54 9280 52 Oct. 10, 1951 Maryland Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No Anne Arundel Glen Burnie Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ 6504 Homewater Court Suite 303 21060 U.S.A. or Itame 23a Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene. snt: if Item 27 is marked other than "natural", or Itame 23 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bfack, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) Coflege (1-4or 5+) Accounts Receivable & Pay. Transportation 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Kenneth Barlow Donna (not available) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21060 Health (Item 27 I Thomas Baker / Husband Suite 303 Glen Burnie, MD. 6504 Homewater Court 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition ö 1

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: if any injury or once. Glen Haven Mem. Park 1/23/2004 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George J. Gonce Funeral Home, P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 anna uneroll Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Finaf **Physician** MYELOMA MULTIPLE resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760 Be Completed by Physiclan/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No P.0. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, FAILURE RENAL 3 Probably 4 Unknown 2 KNo 1 Tyes page 2 should HYPERVOLEMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy THROMBOCYTOPENIA 1 ☐ Yes 2 No Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 3□ DOA Medical Certification: To 2 ER/Outpatient of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending investigation Division 1 Naturaf 1 ☐ Yes 2 ☐ No death 2 Accident 24 hours after deat • Funerel Director: in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 0 pellij the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Jan 20 M.D. D 59766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREENEBAUM CANCER CENTER GORGUN M.D 32, Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

			1 - For State Registrar		State of N		id / Dep		of He	alth an	d Mental		ne 20	04	01937
	Physic	ian	Decedent's Name (Fire	st, Middle, Las	st)						2. Date Mont	of Death	Day	Yeer	3. Time of Death
	/Med		Harold R										122 3		10 55 PM
1	Exam	iner	4a. Facility Name (If not			0 1		100	l.	ocation of D	eath		4c. County	of Deeth	
			5. Social Security Number	spital 6. S		time		If Under	timo	Re (rity		N/A		
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V -	D		Usual Residence of Dece	edent							may	141	וטופ	VA	
	arylar	-		. County		10c. Cit	y, Town or Lo	cation						10	d. Inside City Limits
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200	fter d	E	11. Marital Status 1 □ Never Married	2□ Married	12. Was Deceder Armed Force: 1 ☐ Yes 24	s?	.5.	f Yes, specif	fy Cuban,	Mexican, P	? (Specify Yes ouerto Rican, etc	or No- :.)	14. Hace Black	- America , White, et	n Indian, tc.
93	al', o	þ	3₺ Widowed 4□[If Yes, Give Year or Dates			1 ☐ Yes 2	DXNo 3	Specify:			Specify:	Blac	k
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2	should be filed within 72 hours after death with the Maryland of Mental Hygiene, marked other than "natural", or items 23s or 28s-1 show matic event, its Mcdical Examinar must be notified at		17. Father's Name (First,	Middle (ast)	4		Cont	racto							truction
ä	og la p ♥	Be	James Edv	_	arter						Name (First, M. ia Gas)	
Maryland	2 should be and Mental I is marked o	5	19a. Informant's Name/F				10h Mailir	a Address /			Rural Route N				
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Baltimore,			20a. Method of Disposition				lace of Dispo	sition (Name	e of		Date	-	Location - C		
E	Page nent o int: If		1 ☐ Burial 2 ☐ Cre `4 ☐ Donation 5 🛣	mation 3 🗍 Other (Specify	Removal from Stat Entombro		emetery, crer Wood 1			1/3	1/04	ו בינו	+-		MD
alti	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral			1	22	. Name and	Address o	of Facility N	lutter	Fune	to.	Home	s, Inc.
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At At	Physician percentage with property of the purial-transit the burial-transit the purial-transit the principle of the principle	Examiner	23a. Part1. Enter the dis shock, or heart failu Immediate Cause (Final disease or condition resulting in death) Sequentiafly list condition if any. leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Te. List only c	one cause on each	ine. Ce Ae is a consequ S 1 s a consequ	uence of):				Posis	ry arrest,		1r	oproximate interval Batween onset and Death Clause Clause
8760	ite berei iysician ne buria	ical E			008 to (01 a	s a consequ	ience or):								
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P.O. Box (The law requires that the death certifics ate has been signed by the attending ptoage 2 should be detached for use as It	Physician/Me	IF FEMALE: 23b. Was decedent pregint the past 12 month 1 Yes 2 No 9 Unknown	talit.	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic preg Other (spec					23d. Date Monti	,	ay Year
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ď	w requires been sign should be	pa pa	Chronie	Rei	roll fo	rile	ure				_ 1	☐ Yes 2	2 □ No 3	Probab	y 4 Unknown
Records,	law requas been 2 should	plet	Corona	R4 (arter	u d	isec	ese.			24a. V	Vas an	24b. We	re autopsy	findings available
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d	nding Physician: th. : After this certifica s funeral director, p	P	1 ☐ Yes 2 1 No	ŀ			R/Outpatient	3□ DOA	Other:	4 🗌 Nursing	Home 5□F	lesidence	6 Other	(Specify)	
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. <u>S</u>	Attending or death. ector: After by the fune	icat	2 Accident 3 Suicide 6	Could not be	200 Place of In	ings At her		М		2 🗌 No					
Division	after Direction by	Certification:	4 Homicide	determined	28e. Place of In building, e	tc. (Specify)	ne, rarm, stre	et, factory, o	office		281. Location	n (Street ai Town, Stati	nd Number e)	or Rural R	oute Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 💟 C (Check only 2 🗌 N	ertifying Phy ledicel Exemi	sician: To the best ner: On the basis of and manner s	oi examinatii	vledge, death on and/or inv	occurred at estigation, in	the time, d	date and pla on, death oc	ce, and due to curred at the tir	the cause(s	i) and mann d place, and	er as state d due to the	d. e cause(s)
	To the To the Comp	W	29b. Signature and title of	certifier	0			29c. L	Joense nu	mber		29d. Da	ite signed (Month, Dey	r, Year)
•			>/VIMI	arl	recol			R	ES	-0	00	Jour	uar	422	,2004
	10		30. Name and address of	person who co	ompleted cause of	death (Item :	23a) (Type, F	rint)		, ,	0		R	2 0	· · · · · · · · · · · · · · · · · · ·
	(0		VIIaniyo	2 F.	Dock	Cour	d, n	11)	Sir	nail	lospit	a-K	of t	sa Kt	timore
	Sta Registi		31. Date filed (Month, Day	12820	. 0	rar's Signatu مونانوستار مارجودی	TIE T	fo.	the dead	, .	1				

Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar		ı maryla	Cei	artment of H rtificate of L	Death	Mental Hy	/giene 2	004	01938
	Physici		1. Decedent's Name (First, Midd Anna A. Carli						2. Date of De Month Janua	Day	Year	3. Time of Death
J)	/Medic Examir		4e. Fecility Name (If not institution		,		4b. City, Town, or	Location of Deat			ty of Deeth	2:15 P M
			Holly Hill Nu					Towson		Balt	imore	9
	Funeral Director		5. Social Security Number 069-01-2845	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs	s. last birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Da Dec 2	av. Year)	9. Birthi Coul NY	place (State or Foreign ntry)
	yland Iow		Usual Residence of Decedent 10a. State 10b. Count	у	10c. C	City, Town or Lo	cation					10d. Inside City Limits
	B-fsh	ctor	MD Balt	timore	С	ockeysv	ille					1 ☐ Yes 2 No
	vith th	Funeral Director	10e. Street and Number	_			10f. Zip Code			10g. Citizen of	What Cou	ntry?
	ns 23a	erai	10535 York Ro	ad 12. Was Dece	dent Ever in I	U.S. 13 V	21030	enanio Origina (S	Docify Vac or Ne	United		
Maryland 21215-0036	s I and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygene. I feel them 23a or 28a-1 show fiem 21 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, Ita Madical Examinar must be traillist at	ρ	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	rried 1 Yes	rces? 2 ☑ No e	1	Was Decedent of Hi f Yes, specify Cubai I □ Yes 2 ☑ No		o Rican, etc.)	Speci	ce-Americ ack, White, ify: Whit	etc.
2	72 ho	etec	15. Decede (Specify only high	nt's Education est grade completed)		16a. Deced	lent's Usual Occupa kind of work done d OO NOT use retired,	ition Juring most of wor	kina	16b. Kind of E		
72	within ene. than	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	1	<i>00 NOT u</i> se retired, maker)		Own Ho	ome	
<u> </u>	if Hygin other	Be Co	17. Father's Name (First, Middle	, Last)		Home	marci	18. Mother's Nan	ne (First, Middle	. Maiden Suma	me)	
ylar	should by	ToE	Joseph Anger	rame				Rose F	alcigli	a		
Mar	12 sho h and 7 is m raum	ıı i	19a. Informant's Name/Relation Charles Carli				g Address (Street a				, State, Zip	Code)
	os 1 and 2 of Health item 27 other tra		20a. Method of Disposition	no/son	20b.		lderman C sition (Name of natory or other place		nium, M Date	D 21093 20c. Location	. City or To	State Music
Ē	Pages nent of a int: If its		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (JIAIO		natory or other place ake Crema:		Jan 28 2004	Beltsv		
Baltimore,	permit. Pages Department of Important: If i any injury or it		21. Signature of Funeral Service		M0038	1	Name and Address Cremation	s of Facility a and Fur	neral Al	ternati	.ves	
- 4	20		23a. Part1. Enter the disease, of	Ocumanno or complications that ca	used the dea	ith. Do not ente	8717 Gree or the mode of dying	en Pastur , such as cardiac	res Driv	<u>re Balt</u> rrest.	imore	Approximate
	Physician	7	shock, or heart failure. Lis Immediate Cause (Final disease or condition	at only one cause on ea	ici iirie.		~ ~次					Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):		777	,,			-11
		2	Sequentially list conditions,		as a consor							140
/	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1	. 45 4 5511351	quantes ory.						
\mathcal{F}	e e la la la la la la la la la la la la la	Exa	resulting in death) Last	Due to (c	or as a conse	quence of):						
20/20	tificate be en ig physician as the burial	edical		d								
	h certiff anding use as		IF FEMALE; 23b. Was decedent pregnant	23c. If yes, outc						23d. Da	te of delive	rv
	that the death certificate be enactied ed by the attending physician and detached for use as the burial-transit	hysician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nth 2∏Feta ant at time of o wn		Ectopic pregnancy Other (specify)	· · · · · · · · · · · · · · · · · · ·				Day Year
r.	requires that the	by Pl	Part II. Other significant conditi	ions contributing to de	ath but not res	sulting in the un	derlying cause giver	n in Part I.	23e. Did to	obacco use conf	tribute to th	e cause of death?
ecords	w requires to been signer should be control of the								101	res 2□No	3 🗆 Proba	ably 4 🗷 Onknown
Hec	The law ate has b page 2 sl	Completed							24a. Was autop perfor 1 Yes	rmed?	Were autor prior to con death? 1 \(\sum \text{Yes}\)	osy findings available npletion of cause of
Vital	ysician: is certific director,	Be	25. Was case referred to medica examiner?					26. Place of Deat				
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<u>.</u>	nding ith. r: Afte e fune	ation	1 ☑Natural 5 ☐ Pendir		, Day Year)	Injury	28c. Injury : Work? M 1 \(\sup Ye	es 2 No	20d. Describe n	low injury occur	rea	
DIVISION	to the hospital or Attending Pri within 24 hours after decrete. To the Funeral Directors After th completely filled in by the funeral	Certification;	3 Suicide 6 Could 4 Homicide determ	nined 286. Place	of Injury - At h g, etc. (Speci	oome, farm, stre	et, factory, office		28f. Location (S City or Tow	Street and Numb m, State)	er or Rural	Route Number,
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	withir To th	¥	29b. Signature and title of certifie				29c. License		- 4	29d. Date signe		
7	^		mian Do					1505		1/2	7/04	
	7		30. Name and address of person	who completed cause	of death (Iter	m 23a) (Type, P	rint)	Baltimo		ma 2	-1201	
	Stat Registra		31. Date filed (Month, Day, Year)	8 2004 32. Re	gistrar's Signa	ature G	Some	// *			/	

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** Month Robert R. Collins, Jr. January 22, 2004 6:15 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien Nursing and Rehabilitation Center Mount Airy Carrol1 if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months **M** M 2□ F Days Hours 91 Director 216-05-9888 15 1912 Maryland Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryfend Depertment of Health end Mentel Hygiene. Important: if Itam 27 is marked other than "natural", or items 23s or 28s-1 show any Injury or other traumatic event, the Medical Exament must be multipled at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 25 No Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 713 Midway Avenue 21779 United States 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales LA Benson Co. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert R. Collins, Sr. Alice Woolsev 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1429 Chessie Ct. Mt. Airy, Maryland 21779 <u>Joyce DiDio / Niece</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cem. 1-24-04 Balt., Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4107 Wilkens Ave., Baltimore, MD 21229 23a. Part1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical . ANTERIOSCIERUTIC PARDIOVASCULAN DISEASE 15 411 Examiner Due to (or as a consequence of) Examiner ettending physicien end I for use es the bunel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ Completed 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yes 2 14 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 1 Yes 2 No After this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigetion 1 Natural s efter death. 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral D 1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. 29a. Certifier Medical 2 Medical (Check only 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) D-31912 50 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1564 crossumour Piul Julio MELOCAL MO FREDEROUS, mD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

IAN 2 8 2004

ORIGINAL

			For State Registrar	State of Maryland /		rtment of He tificate of D			jiene leg. No.	2004	019	34		
			Decedent's Name (First, Middle, Last	st)				2. Date of Dea Month	th Day	Year	3. Time of De	ath		
	Physici /Medio		WILLIAM M. CUBBAC	GE .				JANUARY		2004	12:34	A^{M}		
7	Examir		4a. Facility Name (If not institution, give ANNE ARUNDEL MED)			4b. City, Town, or L ANNAPOLI			1	ounty of Death NE ARUNI				
	Funeral Director		5. Social Security Number 6. S 249-38-2092	ex. 7. Age (In yrs. last b ☐M 2☐F 75	virthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day MARCH 2	, Year)	9. Birthp Cour 28 SOUTI	lace (State or F etry) H CAROL	oreign INA		
	٦ ,		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	um or Lo	cation				1	0d. Inside City I	imits		
	shov	5	10a. State 10b. County MARYLAND ANNE AI		APOL					- 1	1 🗆 Yes 2			
	28a-f	ect	10e. Street and Number	KONDEL TIME	11 011-	10f. Zip Code		1	l 0g. Citize	n of What Cour	ntry?			
	23a or	ai Dir	701 GLENWOOD STR			21401				STATE				
21215-0036	be filed within 72 hours after death with the Maryland nat Hygiene. Id other than "natural", or items 23a or 28a-f show of other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No NAV: If Yes, Give Year or Dates: WWII	Y	Vas Decedent of His Yes, specify Cuban Yes 2 No	panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		. Race - Americ Black, White, pecify: W				
o O	72 ho	eted	15. Decedent's Education (Specify only highest gra		a. Decec	lent's Usual Occupat kind of work done du DO NOT use retired)	ion uring most of work	ing	16b. Kind	of Business/Inc	dustry			
7	within lene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired) MPLOYED			RETA	IL SALE	S			
V	Hygie ther ther	င်	17. Father's Name (First, Middle, Last,)			18. Mother's Nam	e (First, Middle,	Maiden Su	ımame)				
<u> </u>		To B	LEIGHTON CUBBAGE			I	ROBERTA	ANDREWS						
3	2 should be and Mental is marked or raumatic ev	-	19a. Informant's Name/Relationship (Туре, Print)	9b. Mailin	g Address (Street ar	nd Number or Rui	al Route Numbe	r, City or T	own, State, Zip				
Σ	ロドトコ		RONALD J. CUBBAG			BUCKINGHA		BALTIMO				7		
Baitimore, maryland	permit. Pages 1 and Department of Heall Important: If item 2 any injury or other 2009.		20a. Method of Disposition 1 Purial 2 Scremation 3 4 Openation 5 Other (Specific	Removal from State	tery, cren CRE	sition (Name of natory or other place, MATORY	JANU. 2004		ATON		MARYLA	ND		
Za Z	permit. Departrimports Imports any inju		21. Signature of Funeral Service Licer	nsee ()		RTRIETANT						<u> </u>		
<u> </u>	205 20		ON ONCh			421 CRAIN				URNIE,	Approximate			
			shock, or heart failure. List only one cause on each line.											
7	Physician /Medical	9	Immediate Cause (Final disease or condition resulting in death)			y sema					y-lavs			
	Examiner			Due to (or as a consequence	e ot):						•			
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Oue to (or as a consequenc	e of):									
V	executed in and ial-transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	c										
Ď	cate be executed bhysician and the burial-transit	Ex	resulting in death) Last	Due to (or as a consequence	e of):									
8/00,	cate be ohysicia the bur	dicai		d										
0	ertific ling p	Mec	IF FEMALE:	23c. If yes, outcome of pregnancy			- Constitution		22	d. Data of delive				
r.O. B 0x	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filed in by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown		Ectopic pregnancy Other (specify)			230	d. Date of delive Month	Day Yea	ır		
	ires that the signed by I be detact		Part II. Other significant conditions	contributing to death but not resulting	j in the u	nderlying cause giver	n in Part I.	23e. Did to	bacco use	cantribute to th	ne cause of dea	th?		
g	quires n sign	d b	Obesity					1 □ Y	es 2 🗀	No 3 Prob	ably 4 Unk	nown		
ဂ္ဂ	aw requir s been si 2 should	Completed by						24a. Was a		24b. Were auto	psy findings ava	ailable		
Ĕ	The law ate has page 2:	E						perfòr		death? 1 ☐ Yes				
Division of Vital Records,	ysician: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?				26. Place of Dea	The second secon						
<u>></u>	Physic this ce al dire	မ	1 ☐ Yes 2 🛣 No	Hospital: 1 Inpatient 2 □ ER/0			4 Nursing H				y)			
Ĕ	ing P	ö	27. Manner of Death 1 Natural 5 Pending	(Month, Day Year)	. Time of Injury	Work!	at ? es 2 □ No	28d. Describe h	ow injury o	occurrea				
<u>s</u>	ttend death ttor: /	icat	2 Accident investigatio	De See Place of Injury - At home	farm str		63 2 140	28f. Location (S	treet and l	Number or Rura	l Route Numbe	Γ,		
<u>></u>	after after Direction by	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	ratti, oti	oot, rastery, emos		City or Tow						
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	dical C		hysician: To the best of my knowled miner: On the basis of examination and manner stated.										
	o the o the omple	Med	29h Signature and otle of certifier			29c. License				signed (Month,	Day, Year)			
>	~ > ⊢ ō		> Spend	Bech, My		D	46052		1]	26/04				
	10		30. Name and address of person who Silend Bulk	completed cause of death (Item 23a 1 MD 2001 Med	a) (Type,	Parkway	, amap	olis, Ms	>					
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature										
	Regist		JAN 2 8 201	04 Alexan	19	don s	,							
DHI	MH 17 Rev 1/2	2001		,		1 - 1 - 1 - 1 - 1 - 1								

			1 - For State Registrar	State o	f Maryla	nd / Dep <i>Ce</i>	artment of F	lealth and <i>Death</i>	Mental Hyg	jiene •g. No.	2004	01941
			1. Decedent's Name (First, Middle	Last)					2. Date of Deat	th		3. Time of Death
я	Physici		KATHLEE	N		CAZ	LEY		JANUAR)	Day 18	Yeer 200H	03:55PM
) :	/Medi Examir		4a. Facility Name (If not institution	-	mber)		4b. City, Town, c	r Location of Dea			ounty of Death	
×,			THE JOHNS	HOPKINS	HOSP	ITAL	BALT	IMORE	CITY			
	Funeral		5. Social Security Number	6. Sex		. last birthday,	If Under 1 Year Months Days	If Under 24 Hr Hours Min	s. 8. Date of Birth	Year	9. Birth	place (State or Foreign
	Director		127-46-2861	1 □ M X (X)F	69	Yrs.	Months Days	Hours Mil	10/15/			aica
	D .		Usuel Residence of Decedent 10a. State 10b. County		100.0	ity, Town or L	contion		, ,			10d. Inside City Limits
	aryla eho	5	Toa. State		100.0	•						1 ☐ Yes 2X No
	28a-1	Director	MD Howar	d		Colu						
	Mith I	ä	10e. Street and Number				10f. Zip Code		'	ug. Citize	en of What Cou	ntry?
	s 23	rai	10290 Day Sta		edent Ever in	16 42	21044	lii- Origina	S	144	USA . Race - Ameri	an Indian
	Item Item	Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Marri	Armed Fo	rces?	J.S. 13.	If Yes, specify Cuba	an, Mexican, Pue	Specify Yes or No- irto Rican, etc.)		Black, White,	etc.
36	Irs af	by F	3 Widowed 4 Divorced	If Yes, Gi	ve		1□Yes 21XNo	Specify:		s	pecify: Bl	ack
ŏ	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28s-f ehow snt, the Medical Evantinar must be rotified at	ed	15. Decedent	s Education		16a. Dece	dent's Usual Occup	ation		16b. Kind	of Business/In	dustry
5	n n	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1.4055.\		kind of work done DO NOT use retired		orking			•
2	N Paris	E	Clementary/Secondary (0°12)	College (1-401 5+)	Tio	Practi	ol Musec		Heal	th Ca	re
פ	il Hygi other	Be C	17. Father's Name (First, Middle, I	ast)		DIC.	Placti	18. Mother's Na	ame (First, Middle, I			
<u>a</u>	buid be Mental arked o atic eve	ToB	Raubert Cazl	еу				Isabel	le Camp	bell	_	
ary	2 should and Men is marks aumatic	 	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Maili	ng Address (Street	and Number or F	Rural Route Number	City or T	Town, State, Zip	Code)
Σ	aith a		Ena Hibbert/	daughte:	r	7310	Cedar I	Ave.,	Jessup,	Md.	20794	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "naturat", or items 23a or 28a-1 ehow any injury or other traumatic event, the Madical Examinar must be notified at once.		20a. Method of Disposition		20b.	Place of Dispe	osition (Name of matory or other place	ce)	Date	20c. Loca	ation - City or To	own, State
Ĕ	Page Tent of		Marial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 ∐Hemoval from ecify)	Co			1	24/2004	Cla	rksvi	lle. Md.
alt	mit. partn ports 7 inju		21. Signature of Funeral Service I	icensee			2. Name and Addre	cc of Equility				
Ö	Depa Impo any ir		1770A9	122		5	555 Twi	wi Knoll	tzke Fu	nera	il HOMe	es, inc.
7	F 9		23a. Part1. Enter the disease, or	complications that	aused the dea							Approximate Interval Between
	Physician		Immediate Cause (Final	13		AILV	28					Onset and Death
**	/Medical		disease or condition resulting in death)	a	(or as a conse		(1 DAY
	Examiner			. SE	PSIS							25 DAYS
- 01		Jer	Sequentially list conditions, cause. Enter Underlying		or as a conse	quence of:					1	
	The law requires that the death certificate be executed ste has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	that initiated events	с.								
o,	an ar	ŭ	resulting in death) Last	Due to	(or as a conse	quence of):						
8760,	nte be nysici ne bu	dical		d								
9	ng ph as th	Sed	IF FEMALE:							-		
Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant	23c. If yes, ou	tcome of pregr		Ectopic pregnancy	,		23	d. Date of delive	
	ne dea the att	SCI	in the past 12 months? 1 ☐ Yes 2 🕱 No		ant at time of		Other (specify)				Month	Day Year
P. O.	that the de ed by the detached	h.	9 □Unknown									
	igned be det	by	Part II. Other significant conditio	ns contributing to d	eath but not re	sulting in the u	nderlying cause giv	en in Part I.				he cause of death?
ord	w requir been si should I	ted		-					1 ∐ Ye	s 2 🗆	No 3 ☐ Prot	pably 4 Unknown
ec	has be	Completed							24a. Was ar autops		24b. Were auto	psy findings available mpletion of cause of
<u> </u>	The ate h page	Š							perform	ned?	death? 1 ☐ Yes	
ita	striffic ctor,	Be (25. Was case referred to medical examiner?					26. Place of De	eath (Check only on	θ)		
<u> </u>	Physician: r this certifica ral director, i	2	1 ☐ Yes 2 🛣 No	Hospital: 1 🖎	Inpatient 2	ER/Outpatie	nt 3 DOA Oth	er: 4 🗆 Nursing	Home 5□ Reside	nce 6 [Other (Specif	y)
ם	ng P		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time o	f 28c. Injur Wor	y at k?	28d. Describe ho	w injury o	occurred	
<u>s</u>	ttendi death. ctor: A / the fu	cati	2 Accident investig	ation			M 1 🗆	Yes 2 □ No				
Division of Vital Records,	after d Direct In by	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	and 289. Flace	of Injury - At I ing, etc. (Spec	nome, farm, st ify)	eet, factory, office		28f. Location (Sti City or Town		Number or Rura	al Route Number,
۵	ited curs af		22 22-2-						1			
	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edicai	(Check only 2 ☐ Medical E	xaminer: On the b	asis of examin	owledge, deat ation and/or in	h occurred at the tir vestigation, in my o	ne, date and plac pinion, death occ	e, and due to the ca curred at the time, da	iuse(s) ar ate and pl	nd manner as s lace, and due to	tated. o the cause(s)
	the hin 2, the land	Med		and man	ner stated.							
•	To Wit	-	29b. Signature and title discertifier				29c. Licens				signed (Month,	
	1.		- Charly					-000	J	NNA	ARY 18	, 2004
	10		30. Name and address of person V				Print)	.) . . =	C C			RYLAND21287
				ALLABH	-		600 NORTH	4 WOLFE	JTREET, BI	4 L 77 m	DRE MA	RYLAND2128
	Sta Registr		31. Date filed (Month, Day, Year)	2004	egistrar's Sigr	A A	and a					

			For State Registrar AMFND ITEM #8 F	State of Maryland ER FH G828 2/04/					giene 2 (004	01942
iù e			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day	Yeer	3. Time of Death
	Physicia /Medic		RICKEY	CHATMAN				1	20 20	04	11:15 A M
	Examin		4a. Fecility Name (If not institution, give st	reet and number)			r Location of Death	1	4c. County		
118			6001 MUNCASTER				VILLE	100.00	MONTG		(0)
30 A	Funeral Director		432-02-3256	7. Age (In yrs. II M 2□ F 49	a <i>st birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da) 10 31	1954 1954	Wilm	ace (State or Foreign try) Ont, AK
	and w		Usuel Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10	Od. Inside City Limits
	Manyli f sho	ō	MD MONTGOMERY	y S	ILVER	SPRING					1X□Yes 2□No
	28a-	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?
	3a o	Funeral Director	1131 UNIVERSITY BI	LVD W. # 602		20902			U.S	.A.	
	death	ner	11. Marital Status	Was Decedent Ever in U. Armed Forces?	S. 13. V	Vas Decedent of H	lispanic Origin? (S	pecify Yes or No		ce - America	
9	or Its	F	1 Never Married 2 Married	1X∏Yes 2 ☐ No If Yes, Give		☐ Yes 2X No	Specify:	,	Specif	7.1	
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23s or 28s-f show ent, the Medical Evananation motified at	d by	3 Widowed 4 Divorced	Year or Dates:	16a Dagge	lent's Usual Occup	antion	1	16b. Kind of B	usiness/Ind	fustor
<u>5</u>	n 72 "nat	lete	15. Decedent's Educ (Specify only highest grade	completed)	(Give	kind of work done OO NOT use retired	during most of wor	king	TOD. KING OF D	431116334114	usuy
12	withi iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 1 yr	Te1	ephone To	echnician	ı	Pri	vate	
פַ	other ent,	Bec	17. Father's Name (First, Middle, Last)					ne (First, Middle,	Maiden Sumar	ne)	-
<u> a</u>	uld be Menta rrked rrked	To B	James Chatman				Fern	Evans			
Baltimore, Maryland 21215-003	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Madical Expiration that the multiple 1 at		19a. Informant's Name/Relationship (Type Fern O. Finley/Mo		19b. Mailin	g Address (Street Univers	and Number or Ru ity Blvd	rai Route Numbe W. #6	or, City or Town, 02 Silv	, State, Zip er Sp	Code) ring Md 20902
ē,	permit. Pages 1 and 2 Department of Health ar Important: If item 27 is eny injury or other trat <u>once.</u>	1	20a. Method of Disposition		lace of Dispo emetery, cren	sition (Name of natory or other place	ce)	Date	20c. Location	- City or To	wn, State
Ë	Page nent c int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State Ri	[verda]	Le Cremat	ory 1-23	-04	Riverda	le,Ma	ryland
ä	Departn Departn Imports eny inju		21. Signature of Funeral Service License			. Name and Addre					
_	89 E 2 A		A.D. Jash	all		7474 Land				yland	
) }	Physician		23a. Part 1. Enter the disease, or complice shock, or heart fullure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	IG CANO		ng, such as cardia	or respiratory a	rrest,	7	Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or as a consequ	uence of):						
	by isi	niner	Sequentially list conditions, if any, leading to immediate cause. Errier United Pring Cause (Disease of injury	Due to (or as a consequ	uence of):		-				
9	cate be executed physician and the burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a consequ	uence of):						
8760	physic physic the bu	dlcal	d								
9 x	certifi nding use as	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna					23d. Da	ate of delive	nry
.O. Box	that the death certific led by the attending p detached for use as	by Physician/Med	In the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fetal 4 Pregnant at time of di 9 Unknown		Ectopic pregnancy Other (specify)	у		Me	onth	Day Year
<u>α</u>	that the ed by detact	Ph.	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did t	obacco use con	tribute to th	e cause of death?
Vital Records,	98 PB							1 X)	Yes 2□No	3 ☐ Prob	ably 4 Unknown
000	w requires been si	Completed						24a. Was		Were auto	psy findings available inpletion of cause of
æ	The law cate has a page 2 s	mo						autor perfo	rmed?	death?	2⊠ No
ital		BeC	25. Was case referred to medical examiner?				26. Place of De	ath (Check only o			
of V	y S	10 [1 ☐ Yes 2 😾 No		ER/Outpatier	II 3LI DOA		lome 5 ☐ Resi			n Hospice
n o			27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	rk?	28d. Describe	how injury occur	rred	
Sio	Attending r death. sctor: After y the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	290 Place of Injury . At he	omo farm et		Yes 2 No	28f Location (Street and Num	her or Rura	i Route Number,
Division	E E	ertification;	4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	y)	eet, factory, office		City or To		50, 0, 1,5,2	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
_	Hospitel 24 hours a Funeral stely filled	edical C		sician: To the best of my kno ner: On the basis of examina and manner stated.							
	To the Hos within 24 h To the Fun completely	Med	29b. Signature and title of certifier	and mainer states.		29c. Licen:	se number		29d. Date signe	ed (Month,	Day, Year)
1	F≽Fö		1 Ken	L~ r	N.)	D35	635		1-20-0	4	
	m		30. Name and address of person who co	impleted cause of death (Item	n 23a) (Type,						
			JOSEPH KAPLAN M				Rockvil	le, Mary	land 2	0902	
		ate	31. Date filed (Month, Day, Year) JAN 2 8 2004	32. Registrar's Signa		for I	my.				
	Regist	100	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 Lings	/ /	700 W 1					

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			For	State of Mary	/land / Dep	artment of	Health and	Mental Hyg	iene	
			1 - State Registrar			ertificate of			eg. No. 2	not nicht
			1 Decedent's Name (First, Middle, Last)			1		2. Date of Dea		3. Time of Death
	Physici	ian	Patrick	T		2621	11	- Month	Day	Year P
N.	/Medi	cal	Latrick	7.	(LOUN			ARY 20	
	Examir	ner	4a. Facility Name (If not institution, give	street and number)	(i -1	4b Gity, Town,	or Location of Dea	ath	1	ty of Deeth
			The Johns H	opkins	HOSPITA	DAC	timore	City	1	/A
-	Funeral		5. Social Security Number 6. Sex		yrs. last birthday	Months Days			Yearl	Birthplace (Stete or Foreign Country)
	Director		217 34 5039 ¹⁸	M 2□F 6	55 Yrs.	Month's Days	riours iviii	July 21	, 1938	Maryland
	7		Usual Residence of Decedent							
	ylan		10a. State 10b. County	10	c. City, Town or L	ocation				10d. Inside City Limits
	Mar	ţ	Maryland Wicomic	_	Willard	ie.				1 ☐ Yes 2 ☑ No
	158 288	Pe	10e. Street and Number		WILLAL	10f. Zip Code		1	On Citizen of	What Country?
	with with	٥	36133 Poplar Nec	k Poad			874		U.S	
	be filed within 72 hours after death with the Maryland hal Hygiene. of other than "natural", or items 23a or 28a-f show event, it a Mudical Examinar must be notified at	Funeral Director		12. Was Decedent Eve	r in 11 C 12			Canada Van an Na		
	er de	Š		Armed Forces?	r in U.S. 13.	If Yes, specify Cut	pan, Mexican, Pue	Specify Yes or No- irto Rican, etc.)		ace - American Indian, ack, White, etc.
36	s aft	by F	1 Never Married 2 Married	1 X Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:		Speci	^{ify:} White
21215-0036	urai	q p	3 Widowed 4 Divorced	Year or Dates: 19	955-58					WILCO
Ŋ	72 nat	ete	15. Decedent's Edu (Specify only highest grade	cation co <i>mpleted)</i>	16a. Dece	edent's Usual Occu e <i>kind of work done</i> DO NOT use retire	pation during most of w	orking	16b. Kind of E	Business/Industry
2	within ene. than "	ldu	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	ed)			
2	filed with Hygiene. Ither than	Completed	12th		Mai	ntainer			Crown	n Cork & Seal
þ	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle, I	<i>Maiden Sum</i> a	me)
a	should by and Menta	To	Patrick	Jefferson (Channell		Fran	ices Polca	k	
2	12 should h and Mer 7 is marke traumatic	-	19a. Informant's Name/Relationship (Ty)			ing Address (Stree		Rural Route Number		State Zin Code)
Maryland				•						, , , , , , , , , , , , , , , , , , , ,
	f Health Item 27 other tr		Audrey Channell 20a. Method of Disposition		20b. Place of Disp	3 Poplar	Neck Roa			faryland 21874
0	1 10		1⊠ Burial 2 □ Cremation 3 □R	emoval from State	cemetery, cre	ematory or other pla	· 1			- City or Town, State
Ë	artmen artmen ortant: injury e.		* 4 □ Donation 5 □ Other (Specify)		Loudon P	ark Cemet	cery 1/2	26/2004	Baltim	ore, Maryland
Baltimore,	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service License	90	/ 2	2. Name and Address	ess of Facility	rae J. Go	nce Fil	neral Home, P.A.
m	89 = 8		- Octomic Inc	muney	11: 1	1001 Ritc	hie High	wav Balt	imore.	Maryland 21225
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the						Approximate
			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.						Interval Between Onsetjand Death
?	Physician		disease or condition resulting in death)	HYPO	lensin	No				2 hours
	/Medical Examiner		Toolsing in coality	Due to (or as a co	ensequence of):	2	1.	: 1		
	LAdminer		Sequentially list conditions	Upper	Gast	rainte	est, Nal	bleed		160 Hours
	T ==	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	ensequence of):					
	be executed sician and burial-transit	E	Cause (Disease or injury that initiated events	Circh	asi's					3 Jears
Ć,	exe in ar	Ex	resulting in death) Last	Due to (or as a co	nsequence of):		0			
760	te be ysicia	cal		Hepati	Lis C	IN	tection	`		10 42 ars
687	icate phys s the			11010	11.0	110	1.0,.0,			10 12015
×	The law requires that the death certificat tile has been signed by the attending phy agge 2 should be detached for use as the	Physician/Med	IF FEMALE:	3c. If yes, outcome of p	***************************************				-	
Вох	ath c	an	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death 3	Ectopic pregnanc	:y			ate of delivery onth Day Year
	e de he a	sic	1 ☐ Yes 2 ☐ No	4☐Pregnant at time 9☐ Unknown	of death 5	Other (specify) _			iati	onth Day Year
P.0	that the de led by the a detached f	'n	9 Unknown							
	s tha	by	Part II. Other significant conditions con	tributing to death but no	ot resulting in the (underlying cause gr	ven in Part I.	23e. Did tob	acco use con	tribute to the cause of death?
Ë	quire n siç uld b							1 □ Ye	s 2 No	3 ☐ Probably 4 ☐ Unknown
Vital Records,	w requires to been signer should be	Completed						24a, Was ar	1045	Mana and an element of the second of the sec
36	e las has je 2	E D						autops	/	Were autopsy findings available prior to completion of cause of
-		ပ္ပ						perform 1 ☐ Yes 2	ZENo	death? 1 ☐ Yes 2 ☐ No
/ite	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					ath (Check only one	9)	
of/	Si ib	၉	1 Yes 2 No H	ospital: 1 Surpatient	2 ER/Outpatie	nt 3□ DOA Ott	her: 4 Nursing	Home 5 ☐ Reside	nce 6 Oth	her (Specify)
0	g PI		27. Manner of Death	28a. Date of Injury (Month, Day Ye.	ar) 28b. Time o	of 28c. Inju Wo		28d. Describe ho		
Division	Attending r death. ector: After by the fune	Certification;	Natural 5 Pending investigation	(month, buy ro	Li) Injury		Yes 2 □ No			
ÌS.	Attended of the syth	100	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	At home, farm, st	reet, factory, office		28f. Location (Str	eet and Numi	ber or Rural Route Number,
S	afte Dir	erti	4 Homicide	building, etc. (S	(pecity)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town	State)	
	ie Hospital or Attendi ≥4 hours after death. • Funeral Director: A tetely filled in by the fu	C	29a. Certifying Phys	ician: To the best of	u kaawladaa daa	hb		1		
	Hos Fun Fun tely	edical	(Check only 2 Medical Exemin	ician: To the best of my er: On the basis of exa	mination and/or ir	an occurred at the ti nvestigation, in my o	me, date and plac opinion, death occ	 and due to the ca urred at the time, da 	use(s) and ma te and place.	anner as stated. and due to the cause(s)
	To the Hospital or Atlending Ph within 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral	Med	5/10/	and manner stated.						
	To vit		29b. Signature and five of certifier)	Λ.	29c. Licens				ed (Month, Dey, Year)
	W) del	M	. 1	128	5000	C	JANUAR	24 21,2004
	'WI		30. Name and address of person who col	mpleted cause of death	(Item 23a) (Type.	Print)				
	10.						FE SWET	BALTIMOR	E. MARY	1LAND 21287
	Sta	te						1 - 1 - 1 - 1 - 1 - 1 - 1		
	Registr		31. Date filed (Month, Pay, Year) 200	4 13 1000	ASS ASS	Mark Co				

			1 - For State Registrar	State of Ma	arylar		artmen rtificat			and M	-	giene Reg. No.	200	4 0191	-
Е	Physici	an	1. Decedent's Name (First, Middle, Last								2. Date of De _ Month	Day	Yea	3. Time of Death	
>	/Medi			uerite	Sk	yles	_	raf			Janua)M
	Examir	ner	4a. Facility Name (If not institution, give						Location o	of Death			ounty of D		
-	Funeral		Frederick Memori 5. Social Security Number 6. Se			last birthday,	If Under		If Under		8. Date of Bir	th	reder		eian
5,	Director			□M 2XF	94	Yrs.	Months	Days	Hours	Min.	Feb. 2	3, 19	19 W	Birthplace (State or Fore Country) Vest Virgin	ia
	72 hours after death with the Maryland naturel', or items 23a or 28a-1 ehow altest Exemples must be motified at		10a. State 10b. County		10c. Ci	ty, Town or L	ocation					***		10d. Inside City Lim	nits
	72 hours after death with the Marylan naturel; or Items 23e or 28e-f ehow dicel Extrairer must be notified at	tor	Maryland Frederi	ck	F	rederi	ck							1 X Yes 2 □	No
	th the	Director	10e. Street and Number				10f. Zip	Code				10g. Citize	n of What	Country?	
	23a	rai	Cottage #29 7431	Willow Roa	ad		2	21702	2			U.S	S.A.		
	tems er m	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		l.S. 13.	Was Deced If Yes, spec	ent of Hi	spanic Ori n, Mexican	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)) - 14	I. Race - A Black, W	merican Indian, /hite, etc.	
36	or I	by F	1 ☐ Never Married 2 █ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑↑ If Yes, Give Year or Dates:	No		1 ☐ Yes	2 🔀 No	Specify:			s	pecify:	White	
21215-0036	turel	ed b	15. Decedent's Edu			16a Dece	dent's Usua	al Occupa	ition			16h Kind		will Le	
15	c * 3	Completed	(Specify only highest grad	le completed)		(Give	kind of wor DO NOT us	rk done d se retired,	uring mos	t of worki	ing	TOD. ITA	or Dusino	Samuasiy	
212	filed within Hygiene. other then "	mo	Elementary/Secondary (0-12)	College (1-4or 5	1+)	T	eachei	c				Educ	ation	n	
힏	e filed al Hygi other vent, l	BeC	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	, Maiden S	umame)		
/lai	should be nd Mental marked o	To E	Henry Moffitt Ha	r1ow					Luc	у Ма	bel Cla	ırk			
Maryland	and and is m	1	19a. Informant's Name/Relationship (T	/pe, Print)		19b. Maili	ng Address	(Street a	nd Numbe	r or Rura	al Route Numb	er, City or T	Town, State	e, Zip Code)	
	1 and 2 Health tem 27		Albert O. Craft	-					431 W					MD 21702	
ore	0 0		20a. Method of Disposition 1X Burial 2 Cremation 3 1	Removal from State		Place of Dispo cemetery, cre			9)		Date	20c. Loca	ation - City	or Town, State	
Ë			*4 □Donation 5 □ Other (Specify,		Sp	ring H			-		3-04	Hunti	ngto	n, WV	
Baltimore,	permit. Pag Department Important: I eny injury o		21. Signarure of Funeral Service Licens	9-1	_		2. Name an				Mortuar	• 37			
	445.44		23a. Part1. Enter the disease, or comp	etumo	u	- 1	328 6	h Ăi	re. H	unti	Mortuar ngton,	WV 25	701	Approximate	
878F/	/Medical Examiner	icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as b. Due to (or as c. Due to (or as d.	a consec	guence of):	erg	VIS	ease						
P.O. Box 68	death certifics e attending ph od for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 XNo 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Feta	il death 3[□Ectopic pro □ Other (sp					23	d. Date of d Month	delivery Day Year	
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions co Demention		ut not res	sulting in the u	inderlying ca	ause give	n in Part I.					to the cause of death? Probably 4 □Unknot	
of Vital Records,	0 - 0	Completed	malnutre	tion							24a. Was autor perfo 1 Yes	osy irmed?		autopsy findings availal to completion of cause of ?	
ita/	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?						26. Place	of Death	(Check only o				
<u></u>	Physician: this certific ral director,	၉	1 ☐ Yes 2 🛣 No			ER/Outpatie			4 🗀 NU	rsing Hor	ne 5□ Resid	dence 6[□Other (S	pecify)	
ū		ü	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	y Year)	28b. Time o Injury		8c. Injury Work			28d. Describe I	how injury o	occurred		
sio	Attending I r death. ector: Atter by the funer	cati	2 Accident investigation 3 Suicide 6 Could not be				М		'es 2 □ !	-					
Division	를 다 다 다	Certification:	4 Homicide determined	28e. Place of Inju- building, etc	ury - At h c. <i>(Specil</i>	ome, farm, st fy)	reet, factory	, office		1	28f. Location (S City or Tox	Street and I wn, State)	Vumber or	Rural Route Number,	
	Hospits 4 hours Funeral	edicai C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of the said manner sta	examina	owledge, deat ation and/or in	h occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the ed at the time.	cause(s) ar date and pl	nd manner lace, and d	as stated. lue to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	0				. License					, -	onth, Day, Year)	
			> Zelwerd ?	John	0			DO	366	10		1	119/	24	
	4		30. Name and address of person who c	omplete cause of d	eath (Iter	n 23a) (Type,	Print)		wy w			· l	11		
	١		Edward F.	Fisher 1	ND	5	6 TI	hoire	5 T	ohN	SON DE	. F	reder	ick Mr	
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signa	ature		_				,		Telling and a second	
	Registi	rar	1119 8 2	nna A		w 1	9	1	10	-91					

		1 - For State Registrar	State of Ma	ryland		artment <i>rtificate</i>			and M		Reg. No.	200)4	0194
Physici		1. Decedent's Name (First, Middle, Last) William T.		Clis	ham					2. Date of De Month Januar	Day	, 200°	ar 4	3. Time of Death 12:49P M
/Medi Examir Funeral		4a. Facility Name (If not institution, give s 305 E. Joppa R 5. Social Security Number 6. Sex	oad Apt	. 70		Tow If Under 1	SON Year	Location o		8. Date of Bir (Month, Da	В	County of Dalling	ore	ace (State or Foreign
Director		216-30-7489 1X	M 2□F	69	Yrs.	Months	Days	Hours	Min.	August 1	1, 193	4 1	Mary	land
he Marylan 8a-f ahow cullied al	ector	Maryland Baltimo	re	Tov	Town or Lo VSON		2-1-				10- 00-	of 18th-		d. Inside City Limits 1 Yes 2 No
th with ti	al Dir	305 E. Joppa Road Apt.	703			10f. Zip (1204				-	en of Wha SA	it Count	ry /
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Modical Exeminal resimilar at 2000.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:		13.	Was Decede If Yes, speci 1 ☐ Yes 2	12	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto f	cify Yes or No Rican, etc.)		4. Race - A Black, V Specify: W	White, e	
pointilling of the profile of the profile of the poor at permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exemple 2008.	ompleted	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5		(Give	dent's Usual kind of work DO NOT use	k done d	lurina most	of workir	ng		of Busin		
build be filled Mental Hygi arkad other	To Be Co	17. Father's Name (First, Middle, Last) Timothy Clisham						18. Mothe		(First, Middle				
od 2 sho lth and 27 is mer r traumer		19a. Informant's Name/Relationship (Ty Joanne Brunsman/Daught			19b. Maili					<i>Route Numb</i> 1timore				Code)
Pages 1 ar nent of Hea nnt: if item:		20a. Method of Disposition 1 💢 Burial 2 Cremation 3 🗆 F 4 🗆 Donation 5 🗆 Other (Specify)	Removal from State	cen	netery, cre	osition (Name matory or oth orest V	e of her place	9)	D	ate	20c. Loc	ation - Cit	y or Tov	
permit. Departnimporta		21. Signature of Funerat Service Licens	on Christina Hulton	L. Hil	ton 2	2. Name and Leon a	ard	s of Facility J. Ru	ıck,	Balti Inc.	more, 5305	Mary Harfo	ylan ord	d 21214 Rd.
law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Ilcal Examiner	tmmediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a Due to (or as a d.	a conseque	nce of):	RUCT	IVE	- /-	Vin	ONARY	DIS	SENSE		Onset and Death YETHES
that the death certificated by the attending pt	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal d	eath 3[⊒Ectopic pre ⊒ Other (spe					2	3d. Date of Month		y Day Year
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9 4 9	Completed	OSTEVARTH	21713							24a. Was auto perfo 1 Yes	psy ormed?	prior deat	r to com	sy findings available pletion of cause of
ding Physician: The Atter this certificat funeral director, p.	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatie 28a. Date of Injur (Month, Day	v 2	R/Outpatie 8b. Time o Injury	nt 3 DO/ of 28	3c. Injury Work	ar: 4 □ Nui	rsing Hon	(Check only one 5⊠Resi 28d. Describe	dence 6		Specify)	
al or Attending s after death. It Director: Attending	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	iry - At hom . (Specify)	ne, farm, st	reet, factory,	office	-	2	28f. Location (City or To		Number o	or Rural	Route Number.
To the Hospital or At within 24 hours after or To the Funerel Direct completely filled in by	edical (29a. Certifier Certifying Phy (Check only one)	sician: To the best of ner: On the basis of and manner sta	examination	ledge, dea on and/or in	th occurred anvestigation,	it the tim in my op	e, date and pinion, deat	d place, a th occurre	ind due to the ed at the time,	cause(s) a date and	and manne place, and	or as sta	ted. the cause(s)
To the 1 To the Complet	Me	20h Cianature and title of codifice	renom					number 0 480	0			signed (A		
51		30. Name and address of person who co			23a) (Type	Print)	767 BA	277M	BELA	MI	COAD	212	36	3, 2004
St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 2 8 20	32. Registra	r's Signatu	re									

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryla	•	nent of Health cate of Deati		/giene Reg. No. 2 (004 01945
C. P. S.	Physician /Medical	Decedent's Name (First, Middle, L KATHERINE	· ·	VIS		2. Date of D Month JAWUA	Dey	Year 8:10 pm
	Examiner Funeral	4a Fecility Name (If not institution, gi North Arund 5. Social Security Number 6.	el Hospital Sex 7 Age (In yrs	s. lest birthday) If U	Gler		Anne	
	Director	217-22-7400 Usuel Residence of Decedent 10a. State 10b. County	1□ M 2)(□ F 85	Yrs.		Min. 8. Date of Bi (Month, D May 12	1918	Maryland
	the Maryle			Pasadena				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	iter death with the Ma r items 23a or 28a-f s inter must be neither funeral Director	1635 Lakewood Ro			f. Zip Code 21122			S.A.
020	72 hours efter death with the Marylend natural; or items 23s or 28s-f show aleal Examiner must be notified at steed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 M No If Yes, Give Year or Detes:	If Yes	Decedent of Hispanic C specify Cuban, Mexico es 2 X No Specif	origin? (Specify Yes or Nan, Puerto Rican, etc.)		e - American Indian, ck, White, etc. ~ white
Baltimore, Maryland 21215-0020	within ene.	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	Education ade completed) College (1-4or 5+)	16a. Decedent's (Give kind of life. DO N Homem	Usual Occupation of work done during mo OT use retired) aker	ost of working	16b. Kind of Bu	
yland	should be filed and Mental Hygis marked other umetic event, I	17. Father's Name (First, Middle, Last George	w Wicklein			ner's Name <i>(First, Middle</i> aze1	_	rooke
, Mar	trau	19a. Informant's Name/Relationship Raymond A. Davis	<i>(Type, Print)</i> s (Husband	19b. Mailing Ad 1635	dress <i>(Street and Numi</i> Lakewood Ro	ber or Rural Route Numb oad, Pasader	ner, City or Town, ina, Md.	State, Zip Code) 21122
imore	Se of L	20a. Method of Disposition 1) Burial 2 Cremation 3 C 4 Donation 5 Other (Speci	Removal from State	Place of Disposition cemetery, crematory dar Hill	or other place)	Date 01/28/04		City or Town, State
Balt	permit. Pag Department Important: I any Injury o page.	21. Signature of Funeral Service Lice	S Neman M	22. Nan	ne and Address of Faci MCCUILY PO 3204 Mounta	lyniak Funer ain Road, Pa		
	Physician /Medical Examiner	23a. P. M. Enter the disease, or consor ck, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a. EMPHYSE			s cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
28760	ficete be executed physician end s the buriel-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	or as a consequence				
Box 6	net the deeth certified by the attending petended for use esented for use explosed for use my Physician/Me		d			- 11.00		
, P.O.	v requires that the death certification is good by the attending should be deteched for use eleted by Physician/M.	Part II. Other significant conditions of	contributing to death but not re-	sulting in the underly	ing cause given in Part			tribute to the cause of deeth? 3 ☐ Probably 4 ☐ Unknown
of Vital Records,	8 8 8					24a. Was	an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?
ital R	iclan: The ic certificate ha rector, page	25. Wes case referred to medical			26. Plea	1 □		1 ☐ Yes 2 No
<u>></u>	Physician: this carific ral director, TO Be (examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 npatient 2	ER/Outpetient 3	DOA Other: 4□N	ursing Home 5 ☐ Resi		or (Specify)
Division o	To the Hospital or Attanding Physician: within 24 hours effor deeth. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (27. Manper of Death 1 ¹ ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐]No	how injury occurre	
Div.	urs efter or at ours efter or all Directified in by	4 ☐ Homicide determined	building, etc. (Speci	fy)		City or To	wn, State)	er or Rural Route Number,
	To the Hospital within 24 hours of To the Funeral Completely filled	one) (Check only 2 Medical Exam	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occu ation and/or investiga	ition, in my opinion, de	nd place, and due to the ath occurred at the time,	date and place, ar	nd due to the cause(s)
	To the To the Common	29b. Significate and title of certifier	ahun Me	S	29c. License number	3	29d. Date signed	(Month, Day, Year)
	15	30. Name end address of person who Zeieke Besse 1	completed cause of death (Itel		way s	liver spri	ng Wb	20904
Ĉ,	State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	eture	Some VI	4		

DHMH 17 Rev 1/2001

Registrar

JAN 2 8 2004

			1 - For State Registrar	State of Ma	ryland / De	partmer e <i>rtifica</i> :				- 1	Reg. No.	2004	0194	9
	Physici /Media	cal	1. Decedent's Name (First, Middle, Claire Elizabet	h Dougherty		45 65	Town or	t anation of		2. Date of Dea Month January	Day 25	Year 2004	3. Time of Death 9:45 A.	
	Examir Funeral	ier	4a. Facility Name (If not institution, Lorien Nursing 5. Social Security Number	and Rehab Co	enter o (In yrs. last birthda	Mour	nt Ai	If Under	24 Hrs.	8. Date of Birt (Month, Da)	C	arroll	nplece (State or Foreign	7
	Director		214-30-4892 Usual Residence of Decedent	1□M 2X)F	70 Yrs.	Months	Days	Hours	Min.	March 6			MD	
	the Marylar 28a-f show	Director	10a. State 10b. County MD Howar 10e. Street and Number	d	10c. City, Town or Ellic	ott Ci	ty Code			···	10a Citiza	en of What Co	10d. Inside City Limits 1 Yes 2 No	
9003	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "naturel", or items 23s or 28s-1 show any injury or other traumatic event, if a Medical Evanting must be routlied at ances.	by Funeral	9852 Diversifie 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	lo	3. Was Dece	21 dent of Hi ecify Cuba 2⊠ No	n, Mexican Specify:	gin? (Spe I, Puerto I	cify Yes or No- Rican, etc.)	14	JSA Race - Ame Black, White	ncan Indian, s, etc. White	
21215-0036	od within 72 giene. er then "ne toe Medic	Completed	(Specify only highest Elementary/Secondary (0-12)		+) (Gi	omemak	ork done d ise retired	during most	t of workir	ng		wn Home	,	
Maryland	should be file and Mentat Hy s marked oth umatic event	To Be (17. Father's Name (First, Middle, La Edgar T. Beach,	Jr.				E1	izab	(First, Middle, eth Rho	ades			
	Health and tem 27 is nother traum		19a. Informant's Name/Relationshi Edward W. Dough 20a. Method of Disposition		98 20b. Place of Dis	52 Div	ersi	fied	Lane	Ellico	tt C:		21042	
Baltimore,	permit. Pages Department of I Important: If the any injury or o		1 ⊠ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Service Li	icify)	Crest L		m. G	ar. (/2004 wab Fun			rille, MD	_
8	90 E 8		23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final	emplications that caused by one cause on each lin	the death. Do not	736 Ed	mond de of dyin	son A	ve.	Baltim r respiratory ar	ore,			
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a	n = (CC) a consequence of:	FIBN	eart alk		on on					
8760,	ate be executed hysician and the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a	i unsequence of):	e fes	_ /	Mel	let	ic15				
P.O. Box 6	the death certifica y the attending ph iched for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetel death	3 □Ectopic p 5 □ Other (s					23	d. Date of deli	very Day Year	
Ś	The law requires that the deate has been signed by the a	by	Part II. Other significant condition	s contributing to death bu	ut not resulting in the	underlying	cause give	en in Part I.		T .	obacco use		the cause of death?	
Division of Vital Record	: The law requ cate has been , page 2 should	Completed								24a. Was autop	rmed?	24b. Were au prior to d death? 1 Yes	copsy findings available ompletion of cause of	1
Ziti	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:			Othe			(Check only of				-
ion of	Attending Physic death. ector: After this by the funeral d	ıtlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Injur (Month, Day			28c. Injury Work	4 DT 110	2	ne 5 🗀 Resid			ify)	
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	the Hospi iin 24 hou the Funer ipletely fill	Medical	(Check only 2 Medical E.	Physician: To the best of caminer: On the basis of and manner sta	examination and/or	investigation	n, in my op	oinion, deal	d place, a th occurre	d at the time, o	date and p	lace, and due	to the cause(s)	
	To with	2		ruh		29	c. License	300	41		29d. Date 1/01 n (signed (Month	1001 PO 200K	
	/2		30. Name and address of person w RAMESIA 31. Date find (Month, Day, Year)	ABAPAT	4/201-1	e, Print)	ade	Rive	1 1	eck v	Road	Balta	11011 HD 2/2	21
	Sta Regist		31. Date filed (Month, Day, Year)	2864 200	ar's Signature	Frank.	,							

			1 - For State Registrar	State of Marylan		nt of Health a te of Death		Reg. No.	01950
	Physici		1. Decedent's Name (First, Middle, Las	DORSEY			2. Date of D Month JANVA	Day Year	3. Time of Death
>	/Medic Examin		4a. Fecility Name (If not institution, give		4b. Cit	y, Town, or Location of	of Death	4c. County of Deeth	
			North West	Hospital	Ra	ndailsta	own	Baltin	
	Funeral		5. Social Security Number 6. Se	The ober	Month	er 1 Year If Under 3	Min. (Month, D	lay, Year) Cour	lace (State or Foreign
	Director		214-68-2842 11 Usual Residence of Decedent	TW SPE H	Yrs.		Apr	04 1957 Ma	ryland
	and and		10a. State 10b. County	10c. Cit	ty, Town or Location			1	0d. Inside City Limits
	Mary Febr	ō	MAD NIA	P	altimor	e Citu			1 Yes 2 □ No
	28a	rec	10e. Street and Number			ip Code		10g. Citizen of What Cour	ntry?
:	3a or		5029 Trues	dolo Aven	110	21206		U.S.A	
	deati	Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. Was Dec		gin? (Specify Yes or N		an Indian,
9	or Ite	臣	1 Never Married 2 Married	1 ☐ Yes 2 SNo If Yes, Give		2 No Specify:	, r dorto ritodii, oto.,		
<u> </u>	ural',	d by	3 Widowed 4 Divorced	Year or Dates:				DI	ack
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Hydiene. The Maryland Reference of the Maryland and the the halfed a most the halffied at	Completed	15. Decedent's Ed (Specify only highest grad		16a. Decedent's Us (Give kind of v	ual Decupation vork done during most use retired)	t of working	16b. Kind of Business/In	dustry
7	within than	m d	Elementary/Secondary (0-12)	College (1-4or 5+)			Tendant	Balto. Co	Schools
0 0	Hygie ther ther	e Co	17. Father's Name (First, Middle, Last)		Carret		n's Name (First, Middle		
Maryland	should be and Mental smarked o	To Be	William F.	Grigge		Mo	rgarett	Duvall	
7	shound Mand	-	WILLIAM E. 19a. Informant's Name/Relationship (7)	ype, Print)	19b. Mailing Addre			ber, City or Town, State, Zip	Code)
	tra tra		William B Grig		5029 Tr	nesdale	Ave. Ball	timore MD 2	1206
ω .	f Heal f Heal item 2 other		20a. Method of Disposition	20b. F	Place of Disposition (N	ame of	Date	20c. Location - City or To	wn, State
Ë	Pages nent of I int: If it		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify				eb 2,2004	Baltonne,	MD
Ħ	permit. Departm Importa any inju		21. Signature of Funeral Service Licen						
œ .	Depa Impo any i		Rurald Och	grayen	108	w, nnch	are. Balti	ral Horre	201
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the deat					Approximate Interval Between
i i	nysician		Immediate Cause (Final disease or condition	a. ACQUIRED	mound of	FRECIENC	V SYNDIZ	ery E.	Onset and Death
	/Medical		resulting in death)	Due to (or as a consec			1 0,130		
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8760	cate be executed physicien and the burial-transit	cai E			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
387	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit			d					
Box 6	certii nding use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna				23d. Date of delive	ery
ŏ	death a atte	ciai	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c				Month	Day Year
P.O.	t the c	hys	9 Unknown	9□ Unknown					
ري. ت	es that the death certific igned by the attending p be detached for use as	by P	Part II. Dther significant conditions of	ontributing to death but not res	sulting in the underlying	cause given in Part I.	. 23e. Did	tobacco use contribute to the	ne cause of death?
Records,	w require been sig should b	edt					1□	Yes 2□No 3□Prob	ably 4 Unknown
000	aw re	Completed					24a. Wa		psy findings available
æ	The law ite has bage 2 a	E O						opsy formed? prior to co death? 2'⊠No 1 □ Yes	npletion of cause of
Division of Vital	ian: rtifica	Bec	25. Was case referred to medical examiner?			26. Place	of Death (Check only		
<u>_</u>	nysic nis ce I dire	2	1 ☐ Yes ZNO	Hospital: 1 Inpatient 2	ER/Outpatient 3 1	ODA Other: 4 Nu	rsing Home 5 Res	sidence 6 Other (Specify	y)
0	ng Pi		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe	how injury occurred	
Sio	eath. or: A the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be		М	1 □ Yes 2 □ I			
Ξ	or Atl fter d Sirect n by	III.	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, factory)	ory, office	28f. Location City or To	(Street and Number or Rura own, State)	I Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate h completely filled in by the funeral director, page		20a Cadillar A Santain St.	releiant To the best of	audadaa deed		d days to the		
	Hos 24 ho Fune felly f	Medical	29a. Certifier Certifying Ph	ysician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date an on, in my opinion, dea	d place, and due to the th occurred at the time	e cause(s) and manner as si , date and place, and due to	tated. the cause(s)
/	ithin i	Med			2	9c. License number		29d. Date signed (Month,	Day, Year)
	F 3 F 8		29b. Signal/Fe and title of certifier	M) M)		D5 418	8	January 2.	2M 2004
	1		30:Warne and address of person who		m 23a) (Type Print)			That are	of Court Pal
	J		Kan swary I	Concern and the control of the contr	Morthy	8t Hospit	racunter	January 2, 5401, 010 MD 2115	33.
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signa				110 -11	
	Registr	ar	JAN 2 8 2004	mound	My And	- W 1 "			

			For State Registrar	State of N	Marylan		artment tificate					giene Reg. No. 2 (004	01951
	Physici	an	1. Decedent's Name (First, Middle, I	~	10,0						2. Date of Dea	Day	Year	3. Time of Death
>	/Medic Examin	al	4a. Facility Name (If not institution, g	DTUM L		HI	4b. City,	Town, or	Location of	of Death	JAN.	4c. Coun	ty of Death	
	Examin		BON SECURE HOSP	ITAL				BA	LTIMO				NA.	
	Funeral		5. Social Security Number 6. 220-68-7427	Sex 7. A 1 ☐ M 2 1 F	Age (In yrs. 6	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day OCT . 8 .	y, Year)	9. Birth	place (State or Foreign intry)
	Director		Usual Residence of Decedent								001. 8,	1938		MD
	aryian ehow	٦	10a, State 10b. County		10c. Cit	y, Town or Lo								10d. Inside City Limits 1 X Yes 2 □ No
	the M	Director	MD 10e. Street and Number	NA		В.	ALTIMO					10g. Citizen o	f What Cou	intry?
	th with		2542 W. PRA	TT STREET				2	1223			U	SA	
	er dee items	Funeral	11, Marital Status	12. Was Deceder Armed Forces	s?	.S. 13.	Was Deced If Yes, spec	lent of Hi ify Cuba	spanic Ori n, Mexican	igin? (Spe 1, Puerto i	cify Yes or No- Rican, etc.)	14. Ra	ace - Amer lack, White	ican Indian, , etc.
036	J within 72 hours after deeth with the Maryland jiene. I then instural, or items 23e or 28e-f ehow II a Madical Exaction must be notified at	۵	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2]X If Yes, Give Year or Dates	-		1 □ Yes 2	2(X No	Specify:			Spec	ify: AFR	ICAN ERICAN
21215-0036	72 ho natura	Completed	15. Decedent's (Specify only highest of			16a. Dece	kind of wor	k done	<i>luri</i> n <i>a</i> mos	t of working	ng	16b. Kind of		
121	within then then	dmc	Elementary/Secondary (0-12)	College (1-40	or 5+)		DO NOT us					7	NA	
d 2	를 갖축 로	Be C	17. Father's Name (First, Middle, La			·	NEVER	WU	RKED 18. Mothe	er's Name	(First, Middle,			
Maryland	should be nd Mental marked o	To								MAE	DRUMW			0.13
Mar	d 2 Trie		JOANN MANNING			100000	100	E010/848			l Route Numbe			p Code)
	ges 1 and t of Health If item 27 or other tr		20a. Method of Disposition 1 □ Burial 2 XCremation 3	(COUSIN)		2202 Place of Dispo semetery, crei		ne of	VALE e)		er BAK ate	TIMORE 20c. Location		21216 own, State
Baltimore,	permit. Peges Department of I important: If it eny injury or o		'4 □Donation 5 □ Other (Spe	cify)		TRO CRI				/31/0	04	CATONS	VILLE	, MD
Bai	Depariment Department of the p		21. Signature of Funeral Service Lic	ensee		`	2. Name an			,	VYLIE F			
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caus	sed the deat	h. Do not ent	er the mod	e of dyin	g, such as	cardiac o	T BAL	rest,	, MD	21217 Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	a Aci	ite	Rena	V F	ai	lure					Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or a	as a conseq	uence of): NSIOA	\							
Ü		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a conseq		J							
	acuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. SE	2129									
60,	be executed sicien and burial-transit	Ical Ex	Toshing in Godin, Edst		as a conseq	INT	ESTIM	Jal	B	LEE	DING			
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Вох	death certificate be executed e attending physicien and od for use as the burial-transit	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	2 Feta	death 3	∃Ectopic pr	egnancy				1	Date of deliver	very Day Year
O.	that the dea led by the at detached fo	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown		leath 5	Other (sp	ecify)						54,
<u>α</u>	The law requires that the tee bas been signed by the bage 2 should be detache	by Ph	Part II. Other significant condition	s contributing to death	n but not res	ulting in the u	nderlying c	ause givi	en in Part I	l.	23e. Did to	obacco use co	ntribute to	the cause of death?
ord	w require been sig should b	ted									1 🗆 Y	res 2□No	3 🗌 Pro	bably 4 Onknown
Records,	has b	Completed									24a. Was autop perfo		b. Were aut prior to co death?	opsy findings available ompletion of cause of
Vital		4	25. Was case referred to medical				-		26. Place	e of Death	1 ☐ Yes	2 No	1 🗆 Yes	200No
of Vi	Physician: r this certificated fral director,	To B	examiner?	Hospital: 1 2 Inpa		ER/Outpatier			4 🗆 NU		ne 5 ☐ Resid			rfy)
o uc	ding Ph h. After th funeral	tlon:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investiga		njury Da <i>y Year)</i>	28b. Time o Injury	f 2 M	8c. Injun Worl	/at <br Yes 2□		28d. Describe h	now injury occ	urred	
Division	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of	Injury - At he etc. (Specif	ome, farm, sti by)					28f. Location (5 City or Tow		nber or Rui	ral Route Number,
	hours a merai D y filled i		29a. Certifier 1 Certifying	Physician: To the be	st of my kno	owledge, deat	h occurred	at the tin	ne, date an	nd place, a	and due to the	cause(s) and	manner as	stated.
	the Hu hin 24 the Fu npletel	Medical	one)	caminer: On the basis and manner		ition and/or in			pinion, dea e number	ath occurre		date and place 29d. Date sign		
	To Too		29b. Signature and title of certifier	1 100	1	0	290	12 C	120	3		Non -	34 4	2004
•	7		30. Name and address of person w	ho completed cause of	of death (Ijeg	п 23а) (Туре,	Print)	ر ب	100		0	MON!	<i>J</i> 1 1	VOO 1
	U		TENNO LAN	NB M. D	C	SON)	5000	NS	HUS	Spita	U B	altin	one 1	Md.
	Sta Regist		31. Date filed (Month, Day, Wear)	8 2004 32. 1	Strains Signa	ature	Grand	2						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death -Month 8:30PM **Physician** HNNIE JANUARY 23 200 /Medical 4b. City, Town, or Location of Death 4c. County of Deat 4a Fecility Nama (If not institution, give street and number) Examiner FUTURE BALTIMOLE PANTON If Under 24 Hrs. 8. Data of Birth Hours Min. Month, Day, Year If Under 1 Year 7. Age (fn yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Months 218 · 20 · 0284 Usual Rasidence of Decedent MARYLAND Director 10a. Stata 10c. City, Town or Location 10d. Insida City Limits 10b. County permit. Pagas 1 and 2 should be filed within 72 hours attar death with the Meryla. Department of Health and Mental Hygiene. Important: if itam 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 1 Yas 2 No BAUTIMORE **Funeral Director** MD 10e. Street and Number 10g. Citizan of What Country? U.S.A. 2123 AIRMONT AVE. 14. Race - American Indian, Black, Whita, etc. 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 1 Yas 2 No If Yas, Giva Year or Datas: 1 ☐ Nevar Married 2 ☐ Married Specify: BLACK 1□ Yes 2M No Saltimore, Maryland 21215-0020 Be Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) NURSE ASSISTANT 18. Mothar's Name (First, Middle, Maiden Sur 17. Fathar's Nama (First, Middle, Last) MARSONS 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) FARMONT AVE BAT MINE, MD 2123/
Jame of Date 20c. Location - City or Town, Stata 1709 E. ERNEST 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1.29.04 ARBUTUS A ARV LAND ARBUTUS CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility VAUGHN C. GREENE FUNEER HOME 21. Signature of Funeral Sarvice Licenses BATTMORE MARYLAND 21212 HOAD YORK 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Daath **Physician** /Medical Immediate Cause (Final disease or condition rasulting in death) Examiner Sequentially list conditions, if any, leading to immediate ceusa. Enter Underlying Causa (Diseasa or injury that infusited events resulting in death) Last Dua to (or as a consequence of) bean signed by the ettending physician should be deteched for use as the burie perfusi Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Wara autopsy findings available prior to complation of causa of death? Completed 24a. Was an autopsy performed? 1 ☐ Yas 2 ☑ No 2 de No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certification completely filled in by the funeral director, 25. Was case rafarred to medical axaminer? 8 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 Othar: 4☑ Nursing Homa 5☐ Rasidance 6☐ Other (Specify) 1 ☐ Yes 20 NO 27. Mann of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Tima of Certification: 1 Watural 5 Panding invastigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as statad.
2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical (Check only one) 29c. License number 29d. Data signad (Month, Day, Year) 29b. Signatura and titla of certifier -

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

- Callana

32. Registrar's Signature

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) 8903

			For	71	aryland / Dep					cgibic.	
		·	For State Registrar		Ce	ertificate d	of Death		Reg. No.	2004	01953
	Physici	an	Decedent's Name (First, Middle, Last,					2. Date of Month	Day	Yeer	3. Time of Death
5	/Medic		MARY VIRGINIA			45 City Tow	m, or Location of De	Janu		. 2004 ounty of Death	
	Examin	er	4a. Fecility Name (If not institution, give WESLEY HOME	street and number)			imore Cit		46.0	N/A	
212	Funeral		5. Social Security Number 6. Sec		e (In yrs. last birthday) If Under 1 Y	ear If Under 24 h		Birth Day, Year)		hplece (State or Foreign untry)
5/2	Director		216-14-1146]M 2√xF	91 Yrs.	Months Da	ays Hours M		. 1912		ryland
80	pud *		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or L	ocation					10d. Inside City Limits
(3)	Maryla febo	ō	Maryland N/A			imore					1X Yes 2 No
22-2004©	n 72 hours after death with the Maryland "natural", or Itame 23a or 28a-f ehow salical Expenies must be notified at	Funeral Director	10e. Street and Number			10f. Zip Co	de		10g. Citize	n of What Co	untry?
2	h with	a D	2211 West Rogers A	venue			21209			USA	
2	аше више	Iner	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13.	. Was Decedent If Yes, specify	of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or lerto Rican, etc.)	No- 14	Race - Amer Black, White	
96	s afte	by Fu	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 1 1 1 If Yes, Give Year or Dates:	No	1 □ Yes 21√2	No Specify:		s	pecify: Wh	ite
0/~ 5 5-0036	tural		15. Decedent's Edu			edent's Usual O			16b. Kind	of Business/I	
215	within 72 ene. then "na	plet	(Specify only highest grad	e completed) College (1-4or 5	life.	e kind of work d DO NOT use re	one during most of stired)	working			
> 32	ould be filed with Mental Hygiene arked other the atic event, the	Completed		2 yrs		Propriet					n/Beauty Car
1/2 Pind	be file	Be	17. Father's Name (First, Middle, Last)					Name (First, Midd			
MAR CXP1R aryland	2 should be filed withir and Mental Hygiene. is marked other then eumatic event, the M	은	Harry Samuel Det 19a. Informant's Name/Relationship (7)		10h Mai	ling Address /St	Mary reet and Number or	Josephi		ullen	in Code)
\ ∑	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Importants if Item 27 is marked other then "natural", or Iteme 23a or 28a-f ehow any injury or other treumatic event, Ita Medical Examinational be notified at any injury or other treumatic event, Ita Medical Examinational be notified at ances.		Richard A. Lamond	(Nephew			osa. Boca				
DETICOLU Ialtimore, I	es 1 and 2 of Health of Item 27 i		20a. Method of Disposition		20b. Place of Disp		f	Date		tion - City or 1	
下 。	Pege nent c ant: If ary or		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	Removal from State	Rose Hil	•		26/2004	Hager	stown,	Maryland
DETIEOU Baltimore,	permit. Pege Department o Important: If any injury or ance.		21. Signature of Fundal Sapard Licen	ee Ewsm				ld Eupor	al Hom	o Tno	
	20599		Martin D. Laws	on		6500 Yo	k Road,	<u>Baltimor</u>	e, Mar	yland 2	21.21.2 Approximate
			21. Signatu/of Fun of Son to Licen Martin D. Laws 23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each li	ne.	nter the mode of	dying, such as card	liac or respiratory	arrest,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. ACUTO	a consequence of):	L F1	ALLU RE				ACUTE
	Examiner		ſ	`	CEMIA						DAYS
1	P ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		a consequence of):						
Oxox	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
8	e be executed sicien and s burial-transit	cal E		Due to (or as	a consequence of);						i
289	10 × 0			d							
Вох	leath certificate attending phy I for use as the	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		□ □ ===================================			23	d. Date of deli	very
. a	he death the atte	sicla	in the past 12 months? 1 □ Yes 2 No	4☐ Pregnant at		☐Ectopic pregn☐ Other (specif			-	Month	Day Year
P.O.	at the	Physician/Med	9 Unknown				i- Badi	on Di	d tobases	- contribute to	the course of docth?
	The law requires that the death certificatie has been signed by the attending phoage 2 should be detached for use as it	by	Part II. Other significant conditions co CHRONIC RG				given in Part I.		JYes 2 🗶	,	the cause of death?
orc	v requ been should	etec	DEMONTIA	- JO 70 A	ull rue iv	<u></u>		24a. W			
Rec	he lav e has ige 2 :	Completed	DETPIEN 1/1F					au pe	rtopsy	prior to c death?	topsy findings available completion of cause of
ta		0	25. Was case referred to medical				26. Place of	1 ☐ Yes Death (Check oni		1 ∐ Yes	2 No
Į Vi		To B	examiner? 1 □ Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatie	ent 3 DOA	Other: 4X Nursin			Other (Spec	city)
0 U	ng Ph fter th ineral		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time y Yeer) Injury		Injury at Work?		e how injury		
sio	tendi death. tor: A	icati	2 Accident investigation 3 Suicide 6 Could not be	One Blace of Ini	un. Athama fare a		1 ☐ Yes 2 ☐ No	29f Lecation	Ctroot and	Number of Cu	ral Route Number,
Division of Vital Records,	l or Ai after d Direc	Certification;	4 Homicide determined	building, et	ury - At home, farm, s c. (Specify)	treet, ractory, or	IIC8		Town, State)	vumber or Au	rai Houle Number,
_	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di		29a. Certifier Certifying Phy	sician: To the best	of my knowledge, dea	ath occurred at the	ne time, date and pl	ace, and due to the	ne cause(s) a	nd manner as	stated.
	the Hin 24 the Fi	Medical	one)	and manner sta	f examination and/or i ated.			ccurred at the tim			
	To To Con	-	29b. Signature and title of certifier	1/100	(D)		iGU 7	_		signed (Month	
	1		30. Name and address of person who c	ompleted a use of d	leath (Item 23a) (Type	D. Print)	11725		1/0	201 200	
	6		ROBERT E. ROB	3 / M.D-	2211 W.	ROGURS	- 19425 AVE-	BALTIN	IORK	MD	21209
	Sta		31. Date filed (Month, Day, Year)		/	/			7		
	Registi	dir.	IAM 2 8 20	OA POR	even of	Ann	been 1				

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth Pecedent's Neme (First, Middle, Last) Dev Month Year **Physician** 9:25pm 4b. City, Town, or Location of Death 2004 /Medical 4c. County of Death 4e Pacility Neme (If not institution, give street end number) Examiner If Under 24 Hrs. 8. Date 6. Sex uce al Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Day, Yeer) **Funeral** Month Days Hours 1 M 2 M Yrs. 219-18-2180 Usuel Residence of Decedent Tune 12, 1925 MARY And Director 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10e. Stete 10b. County ortant: if Nem 27 is marked other than "natural", or Nems 23a or 28a-f show injury or other traumatic event, the Medical Examinar must be notified at 1 Pes 2□ No Funeral Director moRE ARY And 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Was Decedent Ever in U,S. Armed Forces? 11. Meritel Status 12 Black, White, etc. Peges 1 and 2 should be filed within 72 hours efter nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Specify: Black 1□ Yes 2☑No Specify: Maryland 21215-0020 ۵ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupetion
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than any Injury or other traumatic event, the Ma College (1-4or 5+) Elementary/Secondary (0-12) omEstic 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) ton C. DENCER OR5e ANDR 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 21045 14 smanka NE alumbin, 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, 20c. Location - City or Town, Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 2124 23a. Par1. Enter the disease, or complications that caused the death. Do not enter shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Physician immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use es the buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last end Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, attending physician Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? After this certificate has been signed by the a funeral director, page 2 should be deteched to Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1□ Yes 2☑ No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 465 2 No 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSpice Medical Certification: To 1 Yes 2 No 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred I Director: After to ad in by the funera 5 Pending investigation Injury 1 Neturel 1 ☐ Yes 2 ☐ No efter death 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospital of within 24 hours of To the Funeral D 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated. 29d. Date signed (Month, Dey, Yeer) 29b. Signature and title of certifier 29c. License number

State Registrar

JAN 2 8 2004

31. Date filed (Month, Day, Year)

30. Neme end address of person who co

Rise

& Sparks ORIGINAL Baltimore

pleted cause of deeth (Item 23e) (Type, Print)

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Peners

32. Registrar's Signature

DHMH 16 Rev 6/95

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			For State		Sta	ate of M	aryland	-		Health and N	лептат ну	gien	1e 2001.	01055
			Registrar					Cei	tificate of	Deatri	0.00000	Reg. N	10. C. U. U. Y.	3. Time of Death
	Physicia	an	1. Decedent's Name	,	Last)		_				2. Date of De Month	D	ay Year	
3	/Medic		CHARI					ASCH		1	··		2004 lc. County of Death	10:55 p ^M
	Examin		4a. Facility Name (I					i teki miel		r Location of Death				TMODE
			EASTPOIN 5. Social Security N		Sex			ENTEI	If Under 1 Year	TIMORE If Under 24 Hrs.	8. Date of Bi	rth	9. Birthi	IMORE
	Funeral Director		220-24- Usual Residence of	8813	1 X M 2		72	Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, Di MARCH	<i>ау</i> , Уеа 1,	1931 Cou	place (State or Foreign ntry)
	land ow		10a. State	10b. County			10c. City	, Town or Lo	cation					10d. Inside City Limits
	Mary First	ţ	Md.	BALT	IMOR	E		BAL	TIMORE					1 ☐ Yes 2 💢 No
	r 28a	irec	10e. Street and Nur						10f. Zip Code			10g. C	Citizen of What Cou	ntry? .
	72 hours after death with the Maryland natural: or Items 23s or 28s-f show areal Examiner must be neilffed at	Funeral Director	7007 E	. BALT	IMOR:	E STR	EET		212	22			U.S.A.	
	deat	ner	11. Marital Status		A	/as Decedent	?	3. 13.	Was Decedent of H	lispanic Origin? (Si an, Mexican, Puert	pecify Yes or No	0-	14. Race - Ameri Black, White,	
9	after or Ite	Fu.	1 Never Marri		d 1	X Yes 2 □ Yes, Give 'ear or Dates:	No		1 ☐ Yes 2 ☐ No	Specify:	,,		Specify:	
93	iral',	d by	3 Widowed				1948-						WHI	
215-0036	72 h	ete	(Spec	15. Decedent's ify only highest	Education grade con	n npleted)		(Give	lent's Usual Occup kind of work done	during most of work	king	16b.	Kind of Business/Ir	ndustry
21	within ene. than "I	Completed	Elementary/Seco	ndary (0-12)	С	college (1-4or	5+)		OO NOT use retire INSULA			DE	omite entre	CHEET
121	filed withi Hygiene. other ther	ပိ	17. Father's Name	(First Middle 1	est)			FIFE	TNOODA	18. Mother's Nam	ne (First, Middle		ETHLEHEM en Sumame)	STEEL
anc.	ould be ti Mental I arked ot atic eval	To Be	ANDRE		SCH					MARGA		AIN		
Ž	hould d Men narke natic	မ	19a. Informant's N			Print)		19b Mailir	ng Address (Street				or Town, State, Zi	o Code)
Maryland	d 2 sho th and 7 is mu traum		KENNETH			•	MD							2
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene if Health and Mental Hyglene itiam 27 is marked other than "natural", or flems 23s or 28s-f show than traumatic evant, the Modical Examiner must be notified at	- 3	20a. Method of Dis		אנינונ	/ PRIE		ace of Dispo	sition (Name of natory or other pla	Y, DUNDA	Date Date	20c.	Location - City or T	own, State
Baltimore,	eg = 5		1 Burial 2 • 4 □ Donation	Cremation	B □Remov	val from State				ERY 1/2	7/04	DΛ	TUTMODE	MADVIAND
臣	그 분 환 승 .		21. Signature of Fu)		. Name and Addre	ess of Facility				,MARYLAND
Ba	permi Depa Impo any i					Man .		- 1	ILLY &c	ZEILER	INC.F	ÄNĒ	RAL HOM	E D. 21224
			23a. Part1. Enter t	he disease, or d	omplicatio	ns that cause	d the death			ng, such as cardiac			MUIO	Approximate
9			shock, or hea Immediate Cause	rt failure. List o (Final	nly one ca	use on each I	line.	010	1. 1	ent	usian	,		Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	in	e	Due to (or as			ac ore		· · · · · · · · · · · · · · · · · · ·			
	Examiner			- 1		Due to (or as	s a consequ	101100 01).						
		ē	Sequentially list co if any, leading to in cause. Enter Under	nditions, nmediate	b. —	Due to (or as	s a consequ	ience of):						
	uted d ansit	Examiner	Cause. Enter Under Cause (Disease or that initiated events	injury										
Ć.	e be executed sician and e burial-transit	Exa	resulting in death)	Last	C	Due to (or as	s a consequ	ience of):						
09/	e be /sicia e bur	cai			d									
89	leath certificate l attending physi I for use as the b	Physician/Medi			11-02									
Вох	h cer endin	2	IF FEMALE: 23b. Was deceden			i yes, outcome I □Live birth			Ectopic pregnanc	v			23d. Date of deliv	•
	0 0 0	Cis	in the past 12 1 Tes 2	□No	4	Pregnant a			Other (specify)	, 			Month	Day Year
P.0	that the de ed by the detached	h	9 Unknown											
	requires that the een signed by th hould be detache	by	Part II. Other signi	//	is contribu	iting to death	Danot resu	alting in the u	nderlying cause gr W Dise	ven in Part I.	1	_		the cause of death? bably 4 Unknown
ord	w requires to been signer should be	ed	7	- 7	H	100	juie	nona	in cuse	ari	1/2	Yes	2 No 3 Pro	
၁၁	> D 0	Completed	Carro	er of	in	1 yru	VXA	re			24a. Wa:	DDSV	prior to co	opsy findings available empletion of cause of
Œ.	The ate h page	P		V							perf 1 □ Yes	lòrmed?		250 No
Division of Vital Records,	<u>;</u>	Be (25. Was case reference examiner?	red to medical						26. Place of Dea	th (Check only	one)		
<u>5</u>	Physicia this cert al direct	ဥ	1 ☐ Yes 2 🔀	·	Hospi	ital: 1 ☐ Inpati	ient 2□l		IL 3 DOA	a man facility			6 ☐Other (Spec	ify)
0 0	Jing Ph J. After th funeral	ü	27. Manner of Dea	th 5 🗆 Pending		Ba. Date of inj (Month, Da	ury ay Year)	28b. Time o Injury	Wo		28d. Describe	how in	jury occurred	
sio		cati	2 ☐ Accident 3 ☐ Suicide	investiga 6 ☐ Could n	ot be]Yes 2 □No	201	(0)		- I Danta Alverbas
Ξ	or Att	ŧ	4 Homicide	determi	ned 28	Be. Place of In building, e	njury · At ho etc. <i>(Specif</i> y	me, farm, sti ')	eet, factory, office		City or To	(Street own, Sta	and Number or Rui ate)	rai Houte Number,
Q		Medical Certification;		A	Di								/-\ d	
	Hospital 24 hours a Funeral tely filled	ica	29a. Certifier (Check only one)		xaminer:	On the basis	of examinat						(s) and manner as and place, and due	
	To the Hos within 24 h To the Fur completely	Med		title of certifier	1 <	and manner s		/	29c. Licen	se number		29d. [Date signed (Month	, Day, Year)
	7 × 0 0	_	200. Signature and			1	(411	201	1150		01	123/20	204
	, +		1/		.	to all control of	doorb (!	100a) (T	Deint\				1 -10	
	41		30. Name and add MGUT	ress of person v	mo comple	NACS.	M Q	4 U	S. ELL	wood Au	E. BA	LTO	MP 21	224
		ato	31. Date filed (Mor	nth, Day, Year)		32. Regist	trar's Signat	ture enu			1 1 3		1	
	Pogist	ate						9						

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Mary		artmen rtificat			ınd Me		giene Reg. No.	004	01956
	Physicia	an	1. Decedent's Name (First, Middle, Last)	r - 1 -					2	. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	Abraham	Eagle		4h Cihi	Town or	1 ocation o	of Death	01	22 4c Cou	2004 inty of Deat	0121
	Examin		4a. Fecility Name (If not institution, give s NORTHWEST HOSPITAL					Location of TOWN		2	BAL	I IMORE	-
	Funeral Director	1	072 22 0700		yrs. last birthday) Yrs.	If Under Months	Days	If Under: Hours	Min. A	Date of Bird Month, Da PR 22	1928	9. Birti	hplece (State or Foreign untry)
	ahow	or	Usual Residence of Decedent 10a. State 10b. County MD BALTIMORE		ATONSVIL								10d. Inside City Limits 1 ☐ Yes 2 No
	or 28a-f	Direct	10e. Street and Number			10f. Zip					10g. Citizen	of What Co	untry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Itam 27 is marked other than "natural", or Items 23e or 28e-f show simportant: If Itam 27 is marked other than "natural", or Items 23e or 28e-f show shy injury or other traumatic avent, The Medical Examinal medical and once.	by Funeral Director	1324 HICKORY SPRIN 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 .	dent of Hi	spanic Ori n, Mexican Specify:	gin? (Speci , Puerto Ri	fy Yes or No can, etc.)	14.	Race - Ame Black, White Wh ecify:	ncan Indian, a, etc. IITE
21215-0036	within 72 hou ene. then "natura	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	DO NOT u	rk done d	<i>turing</i> mosi	t of working	1		of Business/	industry
land 2	ould be filed Mental Hygis ærked other ætic avent, L	To Be Co	17. Father's Name (First, Middle, Last) AARON HARRY	EAGLE	TOTILITI	<u> </u>		18. Mothe SARAH		First, Middle	Maiden Sur		
Maryland	and 2 should salth and Men n 27 is marke ler traumatic:		19a. Informant's Name/Relationship (Type MRS. TOBIANNE EAGLE		19b. Maili 1324	ng Address HICKO	RY S	PRING	or or Rural I	Route Number	er, City or To ATONSV	wn, State, Z	MD. 21228
Baltimore,	Pages 1 and the source of Heisen int: If itam		20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □ Ro 4 □ Donation 5 □ Other (Specify)	emoval from State	OS FACTOM DISP OS FACTOM ON OOD MOOR								
Balti	permit. Departm Importa any inju		21. Senting of Funeral Service in the	100	8	900 R	EIST	ERST C	WN RC	AD PI	SON & KESVIL		INC. . 21208
No.	Physician /Medical Examiner sthe buriar-transit	i Examiner	23a. Part1. Enter the disease, or compile shock, or heart failure. List poly on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of): Lonic Cardo onsequence of): onsequence of):	ny ce relie e mye pel		g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death Sminales
P.O. Box 6876	death certif e attending id for use as	Physician/Medicai	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	□Ectopic p □ Other (sp					23d.	Date of del Month	ivery Day Year
	uires that t signed by id be detai	by	Part II. Dther significant conditions con	tributing to death but n	ot resulting in the u	underlying (ause give	en in Part I			obacco use		the cause of death?
Records,	The law requires that the sate has been signed by the page 2 should be detache	Completed	Chronic	abstrudire pu	lmonery dis-	હપ				24a. Was auto perfo 1 \(\text{Yes} \)		prior to death?	atopsy findings available completion of cause of
Vital	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	a anital.			0#	2.51		Check only			
of	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director.	tion: To	27. Manner of Death 1 Natural 5 Pending	ospital: 1 Inpatient 28a. Date of Injury (Month, Day Yo	2 ER/Outpatie 28b. Time (Injury		28c. Injun Worl	4 🗆 140	28		dence 6 (city)
Division	or Attendated after death	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e, Place of Injury building, etc. (- At home, farm, si Specify)					3f. Location (City or To		umber or Au	ural Route Number,
	na Hospita 124 hours na Funeral letely fillec	edical C		sician: To the best of mer: On the basis of ex and manner stated	amination and/or in								
	To th within To th compl	Me	29b. Signature and title of certifier Ruhed Chy	, ±0				e number	england		29d. Date si	-	h, Day, Year)
•	(30. Name and address of person who co	mpleted cause of deat	h (Item 23a) (Type	, Print)							
	6		Richard A Bergino	4450 10155		rulle, Hol	21053						
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	. 1000	*						

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	ate of Maryland		artmen tificate			and M		ene 2 (04	01957
	Physic	an	Decedent's Name (First, Middle, Last)	, 1						Date of Death Month	Day	Year	3. Time of Death
5	/Medi		WESTEY CLEVELAND							January.		2004	7.45.Am. M
1	Examir	ier	4a. Fecility Name (If not institution, give street	t and number)				Location of	f Death		4c. Count	y of Death	
	-	-	5. Social Security Number 6. Sex	7. Age (In yrs. last	t birthday)	If Under		If Under 2	24 Hrs.	8. Date of Birth	1/1	2 a Righ	place (State or Foreign
	Funeral Director		212 46 0612 1XM		Yrs.	Months	Days	Hours	Min.	(Month, Day,		Cou	ntry) 5. C.
	1		Usuel Residence of Decedent							aune / J.			
	arylar show	_	10a. State 10b. County	10c. City, T	,								10d. Inside City Limits 1 ∀es 2 No
	he M	ecto	10e. Street and Number	BAI	FINISH		0.1.						
	with t	급	1/2 / / -			10f. Zip	,			10	g. Citizen of	S.A.	ntry?
	urs after death with the Marylar sit, or items 23a or 28a-f show Exerning must be netitied at	Funeral Director	4901 La Sant AVE 11. Marital Status 12.1	Vas Decedent Ever in U.S.	13. V		1200	spanic Orig	in? (Spe	ecify Yes or No-			can Indian,
ထ	or Her	F.	1 ☐ Never Married 2 ☐ Married	med Forces?.					Puerto i	ecify Yes or No- Rican, etc.)		ck, White,	
933		d b		Yes, Give ear or Dates:		¹□Yes 2	2 J25-No	Specify:			Specia	y 819	CIC
21215-0036	d within 72 hours piene. r then "nsturel", ine Mudical Ext	Completed	15. Decedent's Education (Specify only highest grade control of th	n npleted)	6a. Deced	lent's Usua kind of wor DO NOT us	l Occupa k done d	tion uring most	of working	ng 1	6b. Kind of B	usiness/Ir	dustry
121	within ene.	ф	Elementary/Secondary (0-12)	College (1-4or 5+)		ONOTUS OTTEG			,	1	CURRE	1/-	
d 2	Hyg Tt.		17. Father's Name (First, Middle, Last)	0		21184				(First, Middle, M			<u> </u>
lan	Q 2 2 9	To Be	Vagin Louis					Fani		Bennet	,	,	
Maryland	d 2 should th and Mer 7 is marke traumatic	-	19a. Informant's Name/Relationship (Type, I	Print)	19b. Mailin	g Address	(Street a			I Route Number,		State, Zij	Code)
		1	Hichprellan destex woo	d	Jawe.	1 COU	it;	BAH	more	MD	7/236		
Baltimore,	ges 1 an it of Heal if item 2 or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Remo	20b. Place	d of Dispo: btery, cren	sition <i>(Nam</i> n <i>atory or ot</i>	ne of ther place)	Ď	ate 2	Oc. Location		own, State
ij	nit. Pages artment of ortant: If it Injury or o		' 4 □ Donation ' 5 □ Other (Specify)	Cheen	mund	CEME	frey		1/27	104 Hs Fune	BA Home	K MO	
Ball	Department Department Important:		21. Signature of Funeral Service Licensee	_									
	40200		23a. Part 1. Enter the disease, or complication	ns that caused the death. [BA Honor		21213	Approximate
	Physician /Medical Examiner		shock, or heart failure. List only one ca Immediate Cause (Final disease or condition resulting in death) a Sequentially list conditions, if any, leading to immediate	Due to (or as a consequen	ation of):			ng	^		orna		Interval Between Onset and Death
	ate be executed hysician and the burial-transit	lical Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen									
.O. Box 68	s that the death certificat ned by the attending phy e detached for use as th	Physician/Med	in the past 12 months?	yes, outcome of pregnancy □Live birth 2 □ Fetel de □ Pregnant at time of death □ Unknown	ath 3 🗆	Ectopic pre						te of delive	ery Day Year
s, P	sig and b	by	Part II. Other significant conditions contribu	ting to death but not resultin	g in the un	iderlying ca	iuse giver	n in Part I.	dayadayaya	23e. Did toba		nbute to t	ne cause of death?
al Record		Completed								24a. Was an autopsy perform	ed?	Were auto prior to co death? 1 Yes	psy findings available mpletion of cause of
of Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	tal:			Othor		of Death	Check on one			
of	d is	2	1 165 2 2 2 100	1 Inpatient 2 ER	Outpatient b. Time of	-		4 🗀 INUI:		ne 5 Residen			y)
	ng Aftei	tion	1 ØNatural 5 ☐ Pending	(Month, Day Year)	Injury	M	Bc. Injury Work?	ai ? es 2.∐N		8d. Describe hov	injury occur	rea	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be	le. Place of Injury - At home building, etc. (Specify)	, farm, stre					8f. Location (Stre City or Town,		er or Rura	l Route Number,
	the Hospil in 24 hour he Funera pletely fille	edical	Check only 2 Medical Examiner:	n: To the best of my knowled On the basis of examination and manner stated.	dge, death and/or inv	occurred a estigation,	it the time in my opi	date and nion, death	place, a	nd due to the cau d at the time, dat	se(s) and ma e and place,	anner as si and due to	tated. the cause(s)
	with To t	Σ	29b. Signature and title of certifier				License			290	1. Date signe	d (Month,	Day, Year)
	,		P Clubres gag	totus/			וע	0>4¢		<	an Z	6,2	oot
	5		30. Name and address of person who complete Padgett, it	10 5601 r	a) (Type, F	Print) Pave	n Bla	Q, J	Bal	timore,	MD Z	4230	l
	Sta Registi		JAN 2 8 2004	32. Registrar's Signature	9	Soan							
			WILLY V LUUT	p /6		19 16 M	17						

			1- State of Maryland / Department of Health and Me Certificate of Death		2001	01958
			Decedent's Name (First, Middle, Last)	2. Date of Death Month		3. Time of Death
	Physicia /Medic			Sance any	25 2004	11:06 pm
1	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	2.	4c. County of Death	
	Funeval		5. Social Security Number 6. Sex 7. Age (In yrs. yast birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		ce (State or Foreign
ı.	Funeral Director		224-26-5214 Min. 80 Yrs. Months Days Hours Min.	8. Date of Birth Month, Day Yea Sept. 17	,1923 Country	.A.
	pug *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		100	1. Inside City Limits
	Maryla f sho	ro	M.D. N/A Baltimore			1⊠Yes 2□No
	n the	rec	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country	y?
	23a c	aiD	1517 N. Spring Street 21213		U.S.A.	
	within 72 hours after death with the Marylend ene. Than "natural", or items 23a or 28a-f show the Madical Examinar must be mailfied at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married	cify Yes or No- lican, etc.)	14. Race - Americar Black, White, et	
336	urs aft	by F	1 □ Never Married 2 ☐ Married 1 □ Yes 2 ☐ No If Yes, Give 1 □ Yes 2 ☐ No Specify: Year or Dates:		Specify: Blac	k
21215-0036	72 ho	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working	a 16b.	. Kind of Business/Indu	stry
7	vithin ne. han	mple	Elementary/Secondary (0·12) College (1-4or 5+) life. DO NOT use retired)			
р 2	fited v Hygie other t		6th Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)		ltimore C	ity
<u>lan</u>	fental rked c	To Be	James G. Ferguson Mattie S			
Maryland	and N is mai	i b	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural	Route Number, Cit		
Σ ()	and sealth m 27		Rosa Ferguson - Wife 1517 N. Spring St. 20a. Method of Disposition (Name of Day)			
20.	ages 1 nt of H :: If ite		1 ₺ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)		Location - City or Tow	
Baltimore,	permit. Pages 1 and 2 should be fited within 72 hours after death with the Marylen Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. And the many injections if the may 1 is marked other than "natural; or tiems 23 a or 28s-f show any inject or other traumatic event, the Madical Examinar must be mailtied at once.	V	21. Signature of Furreral Service Licensee 22. Name and Address of Facility Nut			
ã	Deparential Depare	l y	Norbert Nutter 2501 Gwynnsfalls			
	100		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arrest,	A Ir	pproximate sterval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Ventricultar Fibritary	Lion	ع	Minutes
16	/Medical Examiner	h Ì	Due (or as a consequence of):			11.0-1.
崖	-э ў	Jer	Sequentially list conditions, any, leading to minimize accuse. Enter Underlying Cause (Disease or injury		U	NE WEEK
	ocuted nd transit	Examiner	that initiated events c. 10		/	ne week
8760	rate be executed hysician and the burial-transit	E	resulting in death) Last Due to r as a c sequence of):			,
687	ficate phys s the	edical	d.	-		
Вох	death certifics e attending ph ed tor use as t	In/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery	
	0 0 0	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Month Da	ay Year
P.0	that the de led by the detached		9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did tobace	use contribute to the	cause of death?
ds,	og De	d by				ly 4 Dunknown
000	aw requir as been si 2 should	Completed		24a. Was an	24b. Were autops	y findings available
<u> </u>		Com		autopsy performed?	death?	letion of cause of
/ita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: Other Other	Check onl one		
ot	00	- To	patient 2 EH/Outpatient 3 DOA 4 Nursing Home	e 5 Residence	6 Other (Specify)	
ion	Attending Physicien: r death. ector: Atter this certific. by the tuneral director.	atior	27. Manner Death 1 atural 5 Pending 2 Accident Investigation 28a. Date of Injury 28b. Time of Injury Work? (Month, Day Year) 1 Injury 28b. Time of Injury 28b. Time of Injury 3b. Time of Injury 3b. Time of Inj		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Division of Vital Record	ai or Attending Phy after death. I Director: Atter this d in by the tuneral d	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Bf. Location (Street City or Town, Sta	and Number or Rural F	loute Number,
Ω	pitel o	Se	CO. Codillos de Constituiro Dividia de Consti			
	To the Hospitel or A within 24 hours after To the Funerel Directompletely filled in by	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an (Check only one) Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the cause I at the time, date a	(s) and manner as state and place, and due to th	ed. e cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier 29c. License number	29d. E	Date signed (Month, Da	y, Year)
,	_		Sara Tolaney, MD RES-000	Jane	iary 27, 2	004
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sara Tolaney Johns Hopkins, Tower 110, 600 Nort	h viole com	ent Ball	0 MN 2120-
	Sta	te		. TUIL SIIT	w, cummor	C, MU 2125+
	Registr	177	JAN 2 8 2004 Serveral AS ASSERTED ASSERTATION OF ASSERTED ASSERTATION OF ASSERTED AS	·		

			Please Type or Print in Black Indelible In			
			1 - State Certificate of Certificate of	of Death	Reg.	No. 2004 01959
	Physici /Medi	al-	1. Decedent's Name (First, Middle, Last) Owen W. Froeming 4a. Fecility Name (If not institution, give street and number) 4b. City, Town		Date of Death Month Jan. 25	Day Year 3. Time of Death 2004 3:30 A
	Examir	er		nsville		Baltimore
	Funeral		Social Security Number Sex 7. Age (In yrs. last birthdey) Months Day Months Day	ar If Under 24 Hrs. 8	Date of Birth	Birtholace (State or Foreign
	Director		216-30-8046		Aug. 23,	1933 Washington
	yland 10w		10a. State 10b. County 10c. City, Town or Location	-		10d. Inside City Limits
	a-f el	ctor	Maryland Baltimore Catonsville			1 Tes 2 No
	or 28	Dire	10e. Street and Number 10f. Zip Code		10g.	Citizen of What Country?
	s 23a	rai	16 N. Bell Grove Road 21228		(USA
36	urs after de al', or Item	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Sive Year or Dates:	of Hispanic Origin? (Specifuban, Mexican, Puerto Rid No <i>Specify:</i>	can, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23e or 28e-f ehow may hayry or other traumatic event, the Medical Examinar must be notified at DDCs.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occ (Give kind of work don life. DO NOT use reti	ne during most of working	166	b. Kind of Business/Industry
	filed withi Hygiene. other than		12 2 Art Director			anufacturing
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than surmatic event, the Ms	Be	17. Father's Name (First, Middle, Last) Emil J. Froeming	18. Mother's Name (F		den Sumame)
Z	should nd Men marke imatic	ဥ		Bess Ower		ity or Town, State, Zip Code)
	1 and 2 Health a tem 27 is					lle, Md. 21228
ore,	of Her of Her filtern rothe		20a. Method of Disposition 20b. Place of Disposition (Name of	Date		. Location - City or Town, State
Ē	Peges ment of I ant: If Its ury or o		1 Burial 2 Cremation 3 Removal from State 4 Donation 3 Other (Specify) Bayview Cremator		04 B	altimore, Maryland
Baltimore,	permit. Peg Depertment Important: I eny Injury o		21. Signature of Funeral Spano to a second s	na		neral Home, Inc.
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of the	tying, such as cardiac or r	Baltimo espiratory arrest,	re, Maryland 21229
	Pnysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	retate 1	Cano	Interval Between Onset and Leath
	/Medical		resulting in death) Due to (or as a consequence of):	USIGIE		27Lyn
	Examiner	_	Sequentially list conditions, b.			
	ted nsit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
Ć,	be executed icien and burial-transit	Examin	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
760,		ā	d			
(687	ortifica ing ph e as th	Med	IF FEMALE:			
.O. Box	The law requires that the death certificate to has been signed by the attending physoage 2 should be detached for use as the	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnant at time of death 5 ☐ Other (specify)			23d. Date of delivery Month Day Year
Ω.	igned by	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause g	given in Part I.	23e. Did tobac	co use contribute to the cause of death?
rds	v requires been sign should be	ed b			1 🗆 Yes	2 No 3 Probably 4 Unknown
I Records,		Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
Vital	rysicien: The	Be	25. Was case referred to medical examiner?	26. Place of Death C	Check only one	
of	7 2 0	. To	Impatient 2 Ervoupatient 3 DOA	Other: 4 Nursing Home	5 X Residence d. Describe how in	6 Other (Specify)
	ding It. Th. After funer	tion	Natural 5 Pending (Month, Day Year) Injury W	vork? □Yes 2□No	J. Describe now i	njury occurred
Division	or Attending after death. Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		Location (Street City or Town, S	t and Number or Rural Route Number, tate)
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the 2 Medical Examiner: On the basis of examination and/or investigation, in my and mannerstated.	time, date and place, and y opinion, death occurred	due to the cause at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the Within	W	29b. Signature and the of certifier 29c. Licer	\\ /8587	2 29d.	Date signed (Month, Day, Year) AN 27. 2004
1	10,1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	AUE &	ALTIM	INE MID 21229
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
DH	MH 17 Rev 1/2		JAN 2 8 2004 french to franks "	P		

ORIGINAL

		Tor State Registrar 1. Decedent's Name (First, Middle, Lasi	State of Maryla		artmen rtificate				Reg. N	20	04 019
Physici /Medic Examin	cal	Gladys C. Fl	andorfer		4b. City,		Location of D		ry 6	ay 06, 20 c. County o	f Deeth
Funeral Director		5. Social Security Number 6. Se	x	last birthday) Yrs.	If Under Months		If Under 24	Hrs. 8. Date of B	irth Day, Year		9. Birthplace (State or Country) Maryland
72 hours after death with the Maryland natural; or items 23a or 28a-1 show Lital Examiner must be motified at	Funeral Director	10a. State 10b. County Maryland Baltim 10e. Street and Number 910 Prestwood Road	ore	ity, Town or Lo			1228				10d. Inside City 1. Yes 2 hat Country?
72 hours after des natural', or Items deal Examiner m	5	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in C Armed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates:		I□Yes 2	No 🛣	Specify:	(Specify Yes or Nuerto Rican, etc.)		Black, Specify:	- American Indian, , White, etc. White
within ene. than	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.	ient's Usua: kind of wor DO NOT usi nemake	k done d e retired)	urina most of	working	16b. K		iness/Industry
ould be filed Mental Hyg arked othe atic evant,	ae Be	17. Father's Name (First, Middle, Last) Roy C. Keeney					Cora			n Sumame)	
1 and 2 sho Health and em 27 is m ither traum		19a. Informant's Name/Relationship (Ty Kelly L. Ewing – G 20a. Method of Disposition	randdaughter		Irwir	ns Cl		Belair,	Mary	land	21014
nt. Fage rtment o rtant: If njury or		1 XBurial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21 Signatur of Funeral Service License	Removal from State WO	cemetery, cren odlawn	Cemet	her place cery	1/2	29/04	Wood	lawn,	ity or Town, State Maryland
Depa Impo any i		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	Cations that caused the deal) 4'	107 Wi	lkir	ns Aver	Hubbard F	imor	al Ho e, Ma	me, Inc. ryland 212 Approximate
death certificate be executed // Medical e attending physician and for use as the burial-transit	dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a	hmia uence of):	audial	in	latetim				Unknos
by the attending platached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2★No 9 □ Unknown	Gc. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Il death 3 🗌	Ectopic pre Other (spe		==0:			23d. Date o Month	•
been signed beshould be detailed	by	Part II. Other significant conditions con	ntributing to death but not res	ulting in the un	derlying car	use giver	n in Part I.		tobacco u Yes 2		ute to the cause of dea ☐ Probably 4 ☐Unk
is certificate has be director, page 2 sh	e Completed	25. Was case referred to medical						1 ☐ Yes	psy ormed? 2 No	prio dea	re autopsy findings avair to completion of causeth? Yes 2 No
is cert direct	To B	eyaminer?	lospital: 1 1 Inpatient 2	ER/Outpatient	3□ DOA	Other		eath <i>(Check only</i> Home 5 Resi		6 DOther	(Canalés)
After t funera	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		c. Injury a Work?	at	28d. Describe			(Spouly)
ref Dir		4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	γ)				City or To	wn, State,)	or Rural Route Number
in 24 h the Fur ipletely	ledical	(Chack only 2 Medical Examinone)	sician: To the best of my kno ter: On the basis of examina and manner stated.	tion and/or inve	estigation, in	n my opir	, date and pla nion, death oc	ce, and due to the curred at the time,	date and	and manne place, and	er as stated I due to the cause(s)
within 2 To the		29b. Signature and title of certifier Bichhum	Jinh, M9		J.	S40	196		_		Month, Day, Year)
. 1	1	30. Name and address of Arson who could be a Di	mpleted cause of death (Item	23a) (Type P	rintl					0	

DHMH 17 Rev 1/2001

Fland or fer, Gladys

		For	State of Ma	aryland / Dep			ental Hygle	ne and	01001
		- State Registrar		Ce	ertificate of	Death	Reg.	No. CUU4	01961
D		1. Decedent's Name (First, Middle,	Last)				Date of Death Month	Day Year	3. Time of Death
Physici /Medio		James	Acoı	гу	Fincham		JANHARY		5:45 AM
Examir		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	r Location of Death	/	4c. County of Deeth	
		VA MARYLAND H.	EALTH CARE	SUSTEM	PERR			Crci	
Funeral		5. Social Security Number 6	i. Sex 7. Ag	e (In ys. last birthday	Months Days	House Min	8. Date of Birth (Month, Day, Ye	ar) 9. Birthpl Count	ace (State or Foreign ry)
Director		229-44-9709	1GM 2□F	73 Yrs.			Dec. 14,	1930 Virg	ginia
pu 🖈		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation			10	Dd. Inside City Limits
aryla shor	٦ ا								1 ☐ Yes 2 ☐ No
Ne M	ecto	VA Warren		Front I			100	Civina - 4 Mart - 4 Course	
ING 21213UU36 be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or flems 23a or 28a-1 show event, the Medical Examinat must be incilited at	Director	10e. Street and Number			10f. Zip Code	_	109.	Citizen of What Count	r y r
s 234	Funeral	376 W. 11th Str	12. Was Decedent	5	22630		ait. Van as Na	USA 14. Race - America	an Indian
er de	n	11. Marital Status		No.	If Yes, specify Cub	lispanic Origin? (Spe an, Mexican, Puerto F	Rican, etc.)	Black, White, e	
Saft Saft	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give C	373/48 to 5/19/52	1☐ Yes 2☐ No	Specify:		Specify: Wh	nite
15-UU36 72 hours af "natural", or adical Exam	Pa	15. Decedent's	Education	16a Dec	edent's Usual Occup	pation	16b	. Kind of Business/Ind	
d 21215- filed within 72 Hygiene. ther than "nat ent, the Medic	Completed	(Specify only highest	grade completed)	(Giv	e kind of work done DO NOT use retire	during most of working)	g		,
with the state of	E	Elementary/Secondary (0-12)	College (1-4or 5	Self	Employed	i	P	ainting Co	mpany
Hygin Hygin and Line	Ö	17. Father's Name (First, Middle, La	ist)			18. Mother's Name	(First, Middle, Maid	den Sumame)	
d be and a second a s	o Be	James Fincham				Emily Je	nkins		
Maryland d 2 should be file th and Mental Hy 7 Is marked oth traumatic event	ဥ	19a. Informant's Name/Relationshi	o (Type, Print)	19b. Mai	ling Address (Street	and Number or Rura	Route Number, Ci.	ty or Town, State, Zip	Code)
Ma nd 2 s alth ar 27 ls r trau		Brenda Chrisman				ter Dr. Fr			
re, N s 1 and t Health item 27 other ti		20a. Method of Disposition	(1,1000)		position (Name of ematory or other pla			. Location - City or Tov	
		1 🖾 Burial 2 🗆 Cremation 3			ematory or other pla : Nat'l Ce		_0/ ₁ C ₁₁	lpeper, VA	
Baltimo permit. Page Department o Important: If any injury or		*4 □Donation 5 □ Other (Special Service Li		(3)			-04 00	rpeper, vi	
Department of the control of the con		MA Can I . I	1 do 10			eral Home			
		232 Part Fotor the disease or o	omolications that cause	the death. Do not ex	05 W. Ma	in St. Fro	nt Royal,	Virginia	Approximate
		23a. Part1. Enter the disease, or c shock, or heart failure. List of	The Park Park Park Park Park Park Park Park		nor the thode or dyn	19, 500, 45 54, 440 51	rospiratory arrost,		Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	a. SEPS						
/Medical Examiner			Due to (or as	a consequence of):	· +	1			
	_	Sequentially list conditions	b. Chron	a cons ence of):	ructive	PUL MON	ary +	SCLISE	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Day **Physician** FISCHER :12 pm Margueritta January 26 2004 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner STELLA MARIS HOSPICE AT MERCY BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Yeer) Birthplece (State or Foreign Country) Funeral 1□M 2₩F 216-28-2784 72 Director Oct.23 1931 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 ☐ Yes 2 ☐ No Md. St. Mary's County **Funeral Director** Hollywood 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 24550 Clarks Landing Lane 20636 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No Specify: Specify: Be Completed by white 3 □ Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tavern 0wner 12 0 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Aubrey **Clarke** Capsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Pindell (Daughter) 11555 Monument Lake Circle, Jacksonville Fla. 32225 20b. Place of Disposition (Name of cemetery, cremetory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Cedar Hill Cemetery 01/28/2004 Baltimore. Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Fecility
McCully-Polyniak Funeral Home P.A 130 E. Fort Ave. Baltimore, Md. 21230 Art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Curcer Examiner Due to (or as a consequence of Physician/Medical Examiner attending physician end of for use es the bunel-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of) within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be deteched for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. DId tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? 21 No 20 No 1 🗆 Yes 1 🗆 Yes 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4□ Nursing Home 5□ Residence 6 ☑ Other (Specify) h DSpice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Menner of Death 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1. Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2004 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Ri SI Davis 31. Date filed (Month, Day, Year) 32. Registrer's Signature State JAN 2 8 2004 Gener Registrar

Vincent A. Ferrari 04-00546

crn		For State Registrar		State of I		d / Depa		of H	leaith	and M	•		200	4 01960
Physic /Med		Vince	me (First, Middle, La ent Ambros	se Ferrar							2. Date of D Month Januar	Day	, 2004	3. Time of Death 8:22 A M
Exami			(If not institution, giv		er)		1		r Location				County of D	
2		5. Social Security	rundel Hos		Age (In yrs.	last hirthday			umie		9 Date of B	- 1		rundel
Funera Director		213-32- Usual Residence	-4987	1 X M 2□F	68	Yrs.	Months	Days	Hours	Min.	8. Date of B (Month, I NOV 23) ay, Year) 193	35	Birthplace (State or Foreign Country) MD
land ow		10a. State	10b. County	· · · · · · · · · · · · · · · · · · ·	10c. City	y, Town or Lo	cation							10d. Inside City Limits
with the Maryland a or 28a-f ehow	tor	MD	Anne Art	undel	G1	en Bui	rnie							1 ☐ Yes 2X☐ No
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23a c	Funeral Director	7629 /	A Spencer	Road				210	60			U	J.S.A.	
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Ind 21215-0036 be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural, or items 23a or 28a-f show event, it a Madical Exeminan must be natilised at	by	_	rried 2 Married 4 Divorced	1 V Yes 2 If Yes, Give Year or Date	□ No es:		1□Yes 2	No K	Specify	r				White
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laryland 212- 2 should be filed within and Mental Hygiene. ie marked other then aumatic event, the M	Be		e (First, Middle, Last h Ferrare	·)					18. Moth		<i>(First, Middi</i> laria F			
Baltimore, Maryland 21215-0036 semil. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mental Hygiene. mportant: if item 27 ie marked other then "natural, or nay highry or other traumatic event, the Madical Exemples.	70	19a. Informant's	Name/Relationship (er		ng Address				a <i>l Route Nu</i> m lestmin			a, Zip Code) 21157
Baltimore, M permit. Pages 1 and 2 Department of Health important: if item 27 any injury or other tre	1.88	20a. Method of D	isposition 2 X Cremation 3 E	Removal from Sta	20b. P	lace of Dispo emetery, crei	osition (Nam matory or of	e of her plac	ce)	Jan 2 2004	Pate 25	20c. Lo	cation - City	or Town, State
Baltim permit. Pa Departmer important: any injury once.			5 □Øther (Speci Funeral Service Lice		11127	/ 22	2. Name an	d Addre	ss of Facili	ity Sin		Fune	eral H	ome, P.A.
		23a. Part1. Enter	r the disease, or comean failure. List only	plications that caus	sed the death								, , , , ,	Approximate
Physician /Medical Examiner		shock, or he Immediate Cause disease or condit resulting in death	e (Final tion	a Athono		i care								Interval Between Onset and Death
\	Examiner	Sequentially list of any, leading to cause. Enter Unit Cause (Disease that initiated ever	immediate derlying or injury	b. Due to (or	as a consequ	uence of).		7 7						
3760, ate be executed hysician and the burial-transit	cal	resulting in death	Last	Due to (or	as a consequ	uence of):								
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on of oding Physith. : After this funeral di		27. Manner of De 1 Natural 2 Accident	5 Pending	28a. Date of I (Month,		28b. Time o Injury		Bc. Injur Wor			28d. Describe			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Divisio Hospital or Attandi 24 hours after death. Funeral Director: A	Certification:	3 Suicide 4 Homicide	6 Could not b	286. Place of	Injury - At ho , etc. (Specify	ome, farm, str	eet, factory	office			28f. Location City or To	(Street and Own, State	d Number or)	Rural Route Number,
Division To the Hospital or Attantion within 24 hours after deat To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)	1 Certifying Pl 2 Medical Exa	hysician: To the be miner: On the basi and manner	s of examina	wledge, deat tion and/or in	h occurred a vestigation,	at the tir	me, date ar pinion, dea	nd place, ath occurr	and due to the red at the time	e cause(s) , date and	and manner place, and d	as stated. lue to the cause(s)
To the I within 2 To the complet	29b. Signature and title of certifier 29c. License number						29d. Dat	e signed (Mo	onth, Day, Year)					
		- hi	i hi.	in. D				(O.C.M	LE.		Janu	ary 20	, 2004

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L(NC) LI M 111 Pe

31. Date filed (Month, Day, Year)

JAN 2 8 2004

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

			1 - For State Registrar	State of N	Maryland / Dep <i>Ce</i>	artment of F			ene 3. No. 200	14 01961	
			1. Decedent's Name (First, Middle	e, Last)				2. Date of Death		3. Time of Death	
	Physic /Medi		Helen		Louise	Fov		January	27 2004		
P.	Examir		4a. Facility Neme (If not institution	, give street and numbe		4b. City, Town, or	r Location of Dea		4c. County of Do		
			7751 Ricker R	oad		Sever	^n		Anne A	rundel	
•	Funeral		5. Social Security Number		Age (In yrs. last birthday,	If Under 1 Year	If Under 24 Hrs			Birthplace (State or Foreign Country)	
М	Director		220-74-9368	1□M 2∏F	94 Yrs.	Months Days	Hours Min		909	MD MD	
	P .		Usual Residence of Decedent								
	aryla mhov	_	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits	
	Ba-f	cto	MD Anne	Arundel	Severn					1 ☐ Yes 2 ☑ No	
	ith th	Sire	10e. Street and Number			10f. Zip Code		100	g. Citizen of What	Country?	
	238	Funeral Director	7751 Ricker Ro	ad		21144			U.	S.A.	
	e de la composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della comp	T P	11. Marital Status	12. Was Deceder Armed Forces		Was Decedent of Hilf Yes, specify Cuba	ispanic Origin? (S	Specify Yes or No-	14. Race - Ar Black, W	merican Indian,	
36	or It	Y.	1 Never Married 2 Marri	ed 1 Tes 21]No	1□ Yes 2√□ No	Specify:	, , , , , , , , , , , , , , , , , , , ,			
ö	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f ahow ent, the Medical Examiract must be notitied at	Completed by	3)☐ Widowed 4 ☐ Divorced	Year or Dates	:	X			Specify: W	hite	
<u>ν</u>	nat nat	ete	15. Decedent (Specify only highes		(Give	dent's Usual Occupa kind of work done of	during most of wa	orking 16	b. Kind of Busines	ss/Industry	
21215-0036	mithir han	ш	Elementary/Secondary (0-12)	College (1-4o	5+)	DO NOT use retired)				
N	iled v tygie ther t		17. Father's Name (First, Middle, I		Homem	iaker	40.410.11.44		Own Hom	e	
ă	be f	Be		· ·				me (First, Middle, Ma	,		
ž	nould I Mer nark	2	Joseph Sczer					chaelina K			
Maryland	12 st n and r ts n		19a. Informant's Name/Relationsh					ural Route Number, C	City or Town, State	, Zip Code)	
ď	l and leath		Mr. Carl Foy /	Son		Ricker Ro			1144		
0	ges If of the		20a. Method of Disposition 1 □ Burial 2 □ Cremation	3 Removal from State	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place	e) Ja	an 30	c. Location - City	or Town, State	
altimore,	tmentant:		* 4 ☐ Donation 5 ☐ Other (Sp	pecify)	Gien Have			2004 G	len Burn	ie, MD	
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Madical Examinar must be notified at once.		21. Signature of Hammar Service L		22	2. Name and Addres	s of Facility S	ingleton F	uneral H	ome, P.A.	
	707 # Q				1	_secona A	venue (alen Burni	e, MD 2	1061	
П			23a. Party. Enter the disease, or shock, or heart failure. List of	complications that cause only one cause on each	ed the death. Do not ent line.	er the mode of dying	g, such as cardia	c or respiratory arrest		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition		0.1	sted Co	rdiom	you The		Onset and Death	
	/Medical		resulting in death)	Due to (or a	s a consequence of):	۸.	11-	1			
1806	Examiner		Sequentially list conditions,	b. ——	D_{i}	ivertica	Mitus	1. 0			
7	D #	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence of):						
	and trans	am	Cause (Disease or injury that initiated events resulting in death) Last	с							
Ä	case be exectined physicien and the burial-transit		resulting in death) cast	Due to (or as	s a consequence of):						
8760	hysic the b	dicai		d							
Ф	eath certifig attending p	Med	IF FEMALE:	<u> </u>							
ROX	thend trend	hysician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth		Ectopic pregnancy			23d. Date of de	,	
0	at the deg by the a tached fo	Sici	1 Yes 2 No	4□Pregnant a 9□ Unknown		Other (specify)			Month	Day Year	
٦.	d by 1 etach	Phy	9 Unknown								
Ś	law requires that the death certificate been signed by the attending to should be detached for use as	ompleted by	23e. Did tobacco u							use contribute to the cause of death?	
0	w require been sig should b							1 🗆 Yes	2 No 3 □ F	robably 4 Unknown	
Records,	e law re has bea je 2 sho	pie						24a. Was an	24b. Were a	utopsy findings available	
	ate pag	Corr						autopsy performed 1 ☐ Yes 2 🔀	i? death? No 1 ☐ Ye	autopsy findings available completion of cause of s	
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only one)	240 1018	3 2127140	
O	Physic this ce al dire	2	1 ☐ Yes 2 ☐No	Hospitat: 1 ☐ Inpati	ent 2 ER/Outpatien	Other		lome 5 Residence	e 6 □Other (Spi	ecify)	
0	ng Pi		27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ury 28b. Time of Injury	28c. Injury Work		28d. Describe how i			
<u> </u>	andir ath. or: Al	atic	2 Accident investiga	ition	injury injury		es 2 □ No				
UNISION	er de recto	ertification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and 288. Place of in	jury - At home, farm, stre	eet, factory, office		28f. Location (Street	t and Number or F	lural Route Number,	
2	tel o rs aft el Di ed in	Cer		building, e	io. (opoury)			City or Town, S	(d1 0)		
	hou hou uner ly fill		29a. Certifier Certifying	Physician: To the best	of my knowledge, death	occurred at the time	e, date and place	, and due to the cause	e(s) and manner a	s stated.	
	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral director.	Medical	one)	xaminer: On the basis of and manner st	x examination and/or inv	estigation, in my opi	nion, death occu	rred at the time, date	and place, and du	e to the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier	\cap		29c. License	number	29d.	Date signed (Mon	th, Dey, Year)	
			liten	16mm	M	10	17 (37)	Jo	awany,	28, 2004	
	10							4 1 20001			
			PETEN MAMI	ntz mb	7845 OA	Mucy) 1	d Suite	20), Cler	18/www	mer 21061	
4 10	Stat		31. Date filed (Month, Day, Year)		rar's Signature	,	1				
	Registra	ır	JAN 2 8 20	NA Same	new My	April 1	mp.				

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First_Middle, Last) 2. Date of Deeth HIRLEY CHARLOHE TERGUSON **Physician** January 23 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, Examiner TELLA BALTIMORE 7. Age (In yrs. Jest birthdey) 5. Social Security Number 9. Birthplace (State or Foreign Country)
WEST VILGINIA **Funeral** Months 1□M 212 F 219.01.8559 Yrs. Director Usuel Residence of Decedent 10b. County 10a. Stete 10c. City, Town or Location 10d. Inside, City Limits injury or other traumatic event, the Medical Examiner must be notified a BALTIMORE 1 PYes 2 No Funeral Director MD10f. Zip Code 10e. Street and Number 10g. Citizen of Whet Country? U.S.A. 1001 12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 14. Race - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 No Specify: BLACK Baltimore, Maryland 21215-0020 Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) COOK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mantel UNKNOWN le merkad UNKNOWA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) BATTIMORE, MD 2/2/8
20c. Location - City or Town, State 3933 KEXMERE KOAD DAVEHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 □ Cremation 3 □ Removal from State 22. Name and Address of Facility YAVEHTN C. GREENE FUNCIAL HOME DRUID KIDETE CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 4905 YORK ROAD BATIMORE, MARYLAND 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Vascilar Disense Examiner Due to (or as a consequence of) by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially fist conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): Part II. Other significant conditione contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice edical Certification: To 1 Yes 2 No this within 24 hours efter deeth.

To the Funeral Director: After this completely filled in by the funeral 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. 29a. Certifier 29b. Signature end title of certifier 29c. License number 29d. Date/signed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

57

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

31. Date filed (Month, Day, Year)

Risebera

410854

PAUL PL.

2004

Baltimore

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 19 FOULER 5:45 AM **Physician** HATTLE L. 2004 /Medical 4c. County of Death
DALTI MORE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE HARBOR HOSPITAL 8. Date of Birth (Month, Day, Feb. 9, 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number ^{Year} 1948 **Funeral** Days Hours 1 □ M 2 X F Maryland 55 214 50 3344 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County or 28a-f show The Medical Exercitive must be notified at 1 ☐ Yes 2 No Director Anne Arundel Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or Itams 23a or i eny injury or other traumatic event. La Waltcal Exam and must be no 21225 U.S.A. 22 Cedar Hill Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 5 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White þ 3 □Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Oscar Stennett Silvia Horseman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Katherine Lanarehr / Daughter 22 Cedar Hill Road Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 1/21/2004 Baltimore, Maryland Bayview Crematory 22. Name and Address of Facility
George J. Gonce Funeral Home, P.A. 21. Signature of Funeral Service Licenses mound 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) NEUMONIA Priysician 2 days /Medical Due to (or as a consequence ot): 2 days **Examiner** SERSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or irjury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760, the attending physician ned for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Obstructive 3 Probably Mumonar 1 ☐ Yes 2 ☐ No 4 Unknown Be Completed peeu cobeles Millenes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Kirral 2 No 2 No 1 Yes director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA Certification: To 2 ER/Outpatient his funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 MNatural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD JANUARY, 19, 2004 First Year Intern 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD-21225 ALI S. HANOVER 57 HARIS 3001 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

VI II I		•	- State Amend Item #4:	State of Ma a per me	laryland / D G823 2/1	epartme Certific	ent of H	ealth and Death	Mental Hy	giene Reg. No. 2	2001	01967
	Db:-:-:		Decedent's Name (First, Middle, Last)				2. Date of De	Day	Year	3. Time of Death		
5		ledical				JANUAI		2004	2:20 P M			
	Examir	ner	4a. Facility Name (It not institution give street and number) UNION VICEOTIAL HOSPITAL 4b. City, Town, or Location of Death BALTIMORE CITY							h 		
, deline	be filed within 72 hours after death with the Maryland distribution. Idea Hygiene. Idea other then "naturel", or Itame 23e or 28e-fehow control of the Markeal Exameration in the Mar		5. Social Security Number 6. Sex 218−14−0275	M 2 🛛 F	ge (In yrs. last birt 93		der 1 Year ns Days	If Under 24 Hrs Hours Min		th 1910	9. Birtt Con Max	nplece (State or Foreign untry) Y I and
		or	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
			MD N/A		Baltir							1 Yes 2 □ No
		Director	10e. Street and Number	·		10f.	Zip Code		1	10g. Citizen	of What Co	untry?
	th with	aiD	522 E. 35th Street			2	1218			Unite	d Sta	tes
36	us after dea	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	? ?No	If Yes, s	cedent of Hi pecify Cuba	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		Race - Amer Black, White ecify: Whit	e, etc.
9	2 hou		15. Decedeni's Educ	cation	16a.	Decedent's U	sual Occupa	ation	rking	16b. Kind o	of Business/I	
21218	I within 7 iene.	Completed	(Specify only highest grade	College (1-4o	(5+) Ca	ife. DO NO andy Sa		luring most of wa)	rking	Retai	1	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If I tem 27 Is marked other then any injury or other traumatic event. The Meagune.	Be	17. Father's Name (First, Middle, Last) Edward Louis Treu	lieb					me <i>(First, Middl</i> e ee Marsl		name)	
ary		2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									ip Code)
			Mr. Vernon Gorwel	l/Son				treet, E	Baltimore			
Baltimore,			20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ R 1 □ Donation 5 □ Other (Specify)	emoval from Stat	A '	Disposition (i y, crematory o peake	or other plac		Date Jan 26 2003	20c. Location		
Balti			21. Signature of Funeral Service License		WEPON	22 Name Crei 871	and Address Mation 7 Gree	s of Facility and Fur n Pastur	neral Al res Driv		ives timore	e, MD
ec	death certificate be executed e attending physician and dior use as the buriat-transit		23a. Pert1. Enter the disease, or compliant shock, or heart failure. List only or	cations that cause	ed the death. Do r							Approximate Interval Between
			Immediate Cause (Final disease or condition		de rotic	cardy	vasa	lar dese	ase			Onset and Death
			Due to (or as a consequence of): Sequentially list conditions									
		a										
Z		Examiner	rr any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events									
8760,			resulting in death) Last	Due to (or as a consequence of):								
687	ficate pphysics the	edicai		J						= 1		
.O. Box	e law requires that the has been signed by th je 2 should be detache	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							23d.	23d. Date of delivery Month Day Year	
Δ.			Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							Did tobacco use conlinbule to the cause of death?		
ıd										1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown		
i Records,		Completed							24a. Was auto perfo 1 Ves	an 24 osy ormed? 2 \(\text{No} \)	death?	topsy findings available completion of cause of
Vital	ysician: Th	Be (25. Was case referred to medical examiner?	laasitali			100		ath (Check only	one)		
of \	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	ဥ	1X Yes 2 No F	lospital:			DOA Oth	# [I lang i	Home 5 Resi			city)
on		tion:	1 Natural 5 ☐ Pending	(Month, Day Year) Injury Work?			280. Describe	28d. Describe how injury occurred				
Division		Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of I building,				28f. Location (City or To	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		Medical Ce	29a. Certifier (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
	o the o the omple	Mec	29b. Signature and title of certifier	and manner	siatou.		29c. License	number		29d. Date sig	gned (Month	n, Day, Year)
	+ 3 ⊢ ŏ		January 21									
	11			10	death (Item 23a) (, , ,	11 Per	on Stree	t. Balti	more	Marvl	and 21201
	Sta	ate	31. Date filed (Month, Day, Year)	32. Regis	Irar's Signature				-, -ALE	- TOLO	. т. у т	white sales
	Regist	rar -	JAN 2 8 2	004	regeral	4	Some	Val.				

ORIGINAL

			- 101	partment of Health and Me		2001 01000			
			Hegistia	ertificate of Death	Reg 2. Date of Death	3. Time of Death			
	Physicia	an .	1. Decedent's Name (First, Middle, Last)		Jan. 25,	Day Year			
9	/Medic		Edward Grimm 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Dair. 25,	4c. County of Death			
	Examin	er	1 Bristol Hill Court, A-1	Catonsville		Baltimore			
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9 Birthplace (State of Foreign			
	Director		220–18–4574 ¹ X ^{M 2□ F} 78 Yrs.	Months Days Hours Min.	(Month, Day, Y Aug. 4,	1925 Maryland			
	p _		Usual Residence of Decedent	1		10d. Inside City Limits			
	within 72 hours after death with the Maryland ene. Than "natural" or tems 23a or 28a-f show Tra Modical Exic ill of mist be notified at	_	10a. State 10b. County 10c. City, Town or			1 ☐ Yes 2 ☐ No			
		acto	Maryland Baltimore Catonsvi		100	2. Citizen of What Country?			
	with ti	吉	10e. Street and Number 1 Bristol Hill Court, A-1	10f. Zip Code 21228		USA			
	s 23g	Funeral Directo	-			14. Race - American Indian,			
_	ter d	Š	11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Never Married 2 ☑ Married 1 ☐ Never Married 2 ☑ Married	 Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F 	lican, etc.)	Black, White, etc.			
5	urs af	þ	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: White			
9500-61212	2 ho	Completed		cedent's Usual Occupation we kind of work done during most of workin		6b. Kind of Business/Industry			
בו בי	thin 7	ople.	Elementary/Secondary (0-12) College (1-4or 5+)	. DO NOT use retired)	9				
N	filed within Hygiene. other then	Col	12 0 Poli			ept. of Transportation			
Maryland		Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		uden Sumame)			
<u> </u>		J.	George H. Grimm	Clara Gr	· · · · · · · · · · · · · · · · · · ·	22 T C A A			
Jai	2 2 2 3			iling Address (Street and Number or Rural					
	ss 1 and 2 should of Health and Mer item 27 is marks other traumatic		20a Mathod of Disposition 20b. Place of Dis	ristol Hill Ct., A-1		Oc. Location - City or Town, State			
altimore,	Pages nent of int: If it		1 Rurial 2 Cremation 3 Removal from State	idge Mem. Pk. 1/31/	/O4 E	lkridge Maryland			
	permit. Pages Department of Important: If it any injury or o		21 Signature of Funeral Service Licensee			neral Home, Inc.			
B	Depi impo		Kichard Conder	4107 Wilkens Ave. B					
Records, P.O. Box 68760,	Itcate be executed /Medical Examiner It the buriat-transit	cal Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C	L COLON CARO	LINOHA	Onset and Death Mo5.			
	the death certi by the attending ached for use a	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death		23d. Date of delivery Month Day Year				
	w requires that been signed to should be det	ρ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown			
	The law recate has bee page 2 shou	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No			
<u> </u>	ysician: Th	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death					
	Phys this al dii	- L	27. Manner of Death 28a. Date of Injury 28b. Time		8d. Describe how				
Division of	ding h. Atter funer	ţ	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 5 Pending (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 5 Pending (Month, Day Year) 37. Manner of Death 5 Pending (Month, Day Year) 48b. Time of 28c. Injury at Work? 48b. Time of 1 Pending (Month, Day Year) 48b. Time of 28c. Injury at Work? 48b. Time of 1 Pending (Month, Day Year) 48c. Injury at Work? 48b. Time of 28c. Injury at Work?						
/ISI	Attending Physician: ir death. ector: Atter this certitics by the funeral director. I	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,	street, factory, office 2		et and Number or Rural Route Number,			
Š	al or atter	Certification:	4 Homicide building, etc. (Specify)		City or Town,	State)			
	To the Hospital or Atlanding I within 24 hours atter death. To the Funeral Director: Atter completely filled in by the funer	Medical (2 Certifier Check only one) Certifying to sician: To the best of my knowledge, de (Check only one) Certifying to sician: To the best of my knowledge, de (Check only one)	eath occurred at the time, date and place, a investigation, in my opinion, death occurre	nd due to the cau d at the time, dat	ise(s) and manner as stated. e and place, and due to the cause(s)			
	To the within 2 To the complet	Me	290 Signature and title of certifie	29c. License number	290	d. Date signed (Month, Day, Year)			
	XI		Jan Harris	D0019419		1006, 16 YAR WAR			
	12, 1		30. Name and address of person who completed cause of reath (Item 23a) (Type	pe, Print)	R				
	1 ()	ate	31 Date filed (Month, Day, Year) 32. Registrar's Signature	OO CATON HUE.	DANT	MORE MD 21239			
	Regist		JAN 2 8 2004	ME A					

ın								2. Date of De			3. Time of Death
al -	Harley		Gob1e	e, Jr.				Janua	ry 22.	year → 2004	1:05 AM M
	4a. Facility Name (If not institution, give	street and number)		4b.	City, Town, o	r Location of	of Death		4c. Co	ounty of Death	
	Casey House				Rockv		0.1.1/			ontgome	
- 1	·V	IM SUE		Mo		Hours	Min.	8. Date of Birt (Month, Da	th IV, Year)	9. Birth <i>Cou</i>	place (State or Foreign intry) th Carolina
			/8	110.				Dec. 1.	1, 192	NOI	th Carolina
Ì	10a. State 10b. County	1	0c. City, Tov	vn or Locatio	n						10d. Inside City Limits
tor	Maryland Montgom	ery	Silver	Spri	ng						1 ☐ Yes 2X No
Sirec	10e. Street and Number			. 10	Of. Zip Code				10g. Citizer	n of What Cou	untry?
					2085	-	2090	06			
nue	11. Marital Status	12. Was Decedent Ev Armed Forces?	°1943-46	13. Was	Decedent of h s, specify Cubi	lispanic Ori an, Mexicar	gin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	- 14.	Race - Amer Black, White	
	3 Widowed 4 Divorced	If Yes, Give		101	Yes 2∭XNo	Specify:			S	oecity: Wh	nite
ed	15. Decedent's Edu	cation		. Decedent's	s Usual Occup	pation			16b. Kind		
plet				(Give kind life. DO N	of work done IOT use retired	during mos d)	t of work	ing			
No.	12	,		(Owner	,			Rest	aurant	:
Be (17. Father's Name (First, Middle, Last)									ımame)	
္	·										
	19a. Informant's Name/Relationship (Ty. FRANCES M., GOBLE	pe, Print) (U.1 E.s.)		_							00000
		(wile)				re ct.					7033
	1 Burial 2 □ Cremation 3 □ R		cemete	ry, cremator	ry or other plac		101	10001			
i i			Stony					/2004	Stony	Point	, NC
	Danie (1)	11/2	,					ome	- N	7 20670	•
+	23a. Part1. Enter the disease, or compli	ications that caused th	e death. Do							. 200/c	Approximate
	Immediate Cause (Final			т с	C						Interval Between Onset and Death
	disease or condition resulting in death)				fiency	1,7 11				-	Years
										1	Years
ner	if any, leading to immediate	Due to (or as a	consequence	of):							
am	that initiated events										
	resulting in death) Last	Due to (or as a o	consequence	· Of):							
dica		J									
/Me	IF FEMALE:	3c. If yes, outcome of	pregnancy						230	Date of deliv	(ACV
clan	in the past 12 months?					у			200	Month	Day Year
lyst	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown					-				
y Pi	Part II. Other significant conditions con	ntnbuting to death but	not resulting	in the underl	ying cause giv	ven in Part I		23e. Did t	obacco use	contribute to	the cause of death?
	S/P Cancer of Lar	ynx						1 🔯 🕆	Yes 2□	No 3□Pro	bably 4 Unknown
plete	Hypertension								an 2	24b. Were aut	opsy findings available ompletion of cause of
E O								perfo	rmed?	death?	
	25. Was case referred to medical					26. Place	of Deat				
	1 ☐ Yes 2 No	lospital: 1 🗌 Inpatient	2 ERVO	utpatient 3	DOA Ott	ner: 4□Nu	ırsıng Ho	me 5 Resid	dence 6	Other (Speci	ny)Hospice
	27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	28b.	Injury				28d. Describe f	how injury o	occurred	
catle	2 Accident investigation			, A	M 1 🗆	Yes 2□	No				
Ě	4 Homicide determined	28e. Place of Injury building, etc.	r · At home, f (Specify)	arm, street, f	factory, office					lumber or Rui	ral Route Number,
	20a Cariffice (A.C. at the art	plain. T. M. L.	man le==- !- !	o de	usement - a se	ma 1-1	1	and dist. 11			
dica	29a. Certifier 1 (Check only one) 2 Medical Exami	ner: On the basis of e	xamination a	nd/or investi	gation, in my o	me, date an opinion, dea	ith occur	and due to the red at the time,	date and pl	ace, and due	stated. to the cause(s)
Med	29b. Signature and title of certifier	and manifol state			29c. Licens	se number			29d. Date s	signed (Month	. Day, Year)
	sul.	Re	MO		DOG	470			Januar	rv 22.	2004
	30. Name and address of person who co	ompleted cause of dea		(Type, Print		.,,			- unuul	- J ~~ ,	
						Ave.	, Ke	nsingto	n, MD		
	edical Certification: To Be Completed by Physician/Medical Examiner	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome 10e. Street and Number 15066 Haslemere C 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade (Specif	246-22-0604	Sequentially list conditions, if any, leading in death) Sequence of conditions, and in the past 12 months? Sequence of conditions, if any, leading in death) Sequence of conditions, and sease of conditions. Sequence of conditions, and sease of conditions. Sequence of conditions, and sease of conditions. Sequence of	Usual Residence of Decadent Tob. County Tob. City, Town or Location Tob. County Tob. County Tob. County Tob. County Tob. City, Town or Location Tob. Mailing Active Tob. City, Town or Location Tob. Mailing Active Tob. Mailing Active Tob. City, Town or Location Tob. Mailing Active Tob. City, Town or Location Tob. Mailing Active Tob. City, Town or Location Tob. Mailing Active Tob. City, Town or Location Tob. Mailing Active Tob. City, Town or L	Usual Residence of Decedent 100. Clipy, Town or Location 100. State 100. County 100. Clipy, Town or Location 100. State 100. County 100. Clipy, Town or Location 100. State 100. Clipy, Town or Location 100. State 100. Clipy, Town or Location 100. State 100. Clipy, Town or Location 100. State 100. Clipy, Town or Location 100. State 100. Clipy, Town or Location 100. State 100. Clipy, Town or Location 100. State 100. Clipy, Town or Location 100. State 100. Clipy 100. Clipy, Town or Location 100. Clipy, Town or Location 100. Clipy, Town or Location 100. Clipy, Town or Location 100. Clipy, Town or Location 100. Clipy, Town or Location 100. Clipy 100. Cli	246-22-0604	246-22-0604	Description Description	December December	Dec. 11, 1923 No.

DHMH 17 Rev 1/2001

Physician

/Medical

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Directo

Funeral

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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I SR.	State of Maryland / Department of Health and Menta
For State Registrar	Certificate of Death

al Hygiene	0	0		*	0			
Reg. No.	4	U	U	1.5	U	9	1	- steellester

Baltimore, Maryland 21215-0036		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Denartment of Haalth and Mantal Huniane.	F D	
Important: if Item 27 is marked other than "natural", or items 23a or 28s-1 show eny injury or other traumatic event. It's Modical Examinar must be notified at	unera	Exan

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day 22, 2004 Sr. Roger Lee Gordon JAN. 1925 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth NORTH ARUNDEL HOSPITAL GLEN BURNIE ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Sept, 03 1942 Birthplace (State or Foreign Country) 1 ☑ M 2 ☐ F 218-44-0230 61 Yrs. MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8371 Penn Drive 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No White Specify: Specify: à 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tree Trimmer Asplundh Tree Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Michael Gordon Henry Eleanor Cunningham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8116 Main Creek Road, Pasadena, MD 21122 Roger L. Gordon, Jr. (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Jan. 28 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery Baltimore, Maryland * 4 ☐Donation 5 ☐ Other (Specify) 2004 21. Signature of Funeral Service Liberisee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 Part 1. Enter the disease, or complications that passed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one or unless hims. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Head and Chest Injuries Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of):

Physician /Medical Examiner

attending physician and for use as the burial-transit

Division of Vital Records, P.O. Box 68760 or Attending Physician: The law requires that the death certificate be Examiner

Physician/Medical

ģ

Completed

Be

2

Certification:

Medical

After

Director:

within 24 hours a To the Funeral I

death.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No

25. Was case referred to medical

1 XYes 2 ☐ No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

23c. Il yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death Check onl one

1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ▼Yes 2 □ No

23, 2004

Hospital: 1 Inpatient 2006 Pl/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred

Pedestrian struck by motor 12/04 1 Yes 2 No venucle

Place of Injury - Al home, farm, street, lactory, office building, etc. (Specify) Road

Location (Street and Number or Rural Route Number, City or Town, State) Mcuntain Rd West Penn D Pasadena, MD

JAN.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year)

hi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LI. m.O LING

5 Pending

investigation

6 ☐ Could not be

111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date liled (Month, Day, Year)

32. Registrar's Signature JAN 2 8 2004 Garas

O.C.M.E

					artment of Health and I		-	
			1 - State Registrar		rtificate of Death		g. No. 2004	01971
	Physic	ian	Decedent's Name (First, Middle, Last)			2. Date of Deat Month	h Day Year	3. Time of Death
-	/Medi	cal	EDWARD JOHN GUINN 4a. Facility Name (If not institution, give street as	and accomplished	4. 65. 7.	JANUARY	28, 2004	6:45 A M
	Exami	ner	MARINER HEALTH OF GL		4b. City, Town, or Location of Death GLEN BURNIE	1	4c. County of Deat ANNE ARUN	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,		nplece (State or Foreign untry)
١.	Director		212-36-6241 Usuel Residence of Decedent	□ F 66 Yrs.	Months Days Hours Min.	OCT. 19	1937 PENN	ISYLVANIA
	darylan f show	5	10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	or 28a-	Director	MARYLAND ANNE ARUNDEL 10e. Street and Number	SEVERN	10f. Zip Code	10	og. Citizen of What Co	
	eath w		7959 TELEGRAPH ROAD		21144		UNITED STA	
920	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "naturel", or Itams 23e or 28e-f show event, itse Madical Examiner must be muillind at	by Funeral	1 Never Married 2 Married 1 If Ye	Yes 2)(□No	Vas Decedent of Hispanic Origin? (Sif Yes, specify Cuban, Mexican, Puert □ Yes 2 X No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, White Specify: [W	
21215-0036	ithin 72 ho ie. ien *natur i M. cirel I	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Colle	eted) (Give:	lent's Usual Occupation kind of work done during most of wor OO NOT use retired)	king	6b. Kind of Business/I	ndustry
N			9	AUTO	MECHANIC		UTO REPAIR	
anc		o Be	17. Father's Name (First, Middle, Last) BENJAMIN GUINN		ISABEL H	ne (First, Middle, M NDDTC	faiden Surname)	
Maryland		To.	19a. Informant's Name/Relationship (Type, Prin	t) 19b. Mailin	g Address (Street and Number or Ru		City or Town, State, Z	ip Code)
	5 = N L		TIMOTHY R. GUINN - SON			EVERN, MA		144
Baltimore,	of of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal	nom State	natory or other place) JANU	ARY 29	Oc. Location - City or 1	own, State
Itim			*4 □Ponation 5 □Other (Specify) 21. Sign trun 1 Foneral Service Licensee	METRO CR	the state of the s	JEDAT HON		E, MARYLAND
Ba	permit. Departr Importe any inji		A LICENTA		RKEEY ARUSDICK FUI 21 CRAIN HIGHWAY (E P.A. N BURNIE,	21061 MARYLAND
1	Physician /Medical Examiner popularitansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	CONGESTI The to (or as a consequence of): CORONARY The to (or as a consequence of): Hyperale	VE HEART	or respiratory arre	E	Approximate Interval Between Onset and Death
P.O. Box 68760,	death certifica e attending ph id for use as th	Physician/Medical E	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Vas 2 No.		Ectopic pregnancy Other (specify)		23d. Date of deliv	ery Day Year
	w requires that the been signed by th should be detache	by	Part II. Other significant conditions contributing CEREBRUVASCU	to death but not resulting in the un			acco use contribute to	
Rec	The law ate has b page 2 sl	Completed				24a. Was an autopsy perform	ed? death?	opsy findings available impletion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		T Au	h (Check only one)	
o		. To	1 ☐ Yes 2 No Hospital:	1 Inpatient 2 ER/Outpatient Date of Injury 28b. Time of	3 □ DOA Other: 4 Nursing Ho	me 5 Residen	ce 6 Other (Speci	(y)
ion	nding ath. r: Afte e fune	ation		(Month, Day Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	200. 0450104 1104	rinjury occurred	
Divis	To the Hospitel or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification;	3 Suicide 6 Could not be determined 28e.	Place of Injury · At home, farm, stre ouilding, etc. (Specify)	et, factory, office	28f. Location (Stre City or Town,	et and Number or Run State)	al Route Number,
	ne Hospitel n 24 hours a ne Funeral t pletely filled	edical	Conserving 2 Medicel Examiner: On	o the best of my knowledge, death the basis of examination and/or inve manner stated.	occurred at the time, date and place, estigation, in my opinion, death occur	and due to the cau red at the time, dat	ise(s) and manner as s e and place, and due t	stated. the cause(s)
	To the within 2. To the I complete	M	29b. Signature and fixle of certifier		29c. License number	296	d. Date signed (Month,	Day, Year)
7			1 / Lower	orne, mo.	17753		1/28/	04.
	\		30. Name and address of person who completed $K \cdot S \cdot D$ HARMAS	cause of death (Item 23a) (Type, P	tion) 710 CHURCH ST	· BAL	TIMORE, A	1021225
4	Sta Registr			32. Registrar's Signature				

DHMH 17 Rev 1/2001

			1_ For	State of Maryl		artment	of He	ealth a		•	iene		010	70
			Registrar		Cei	rtificate	of L	eatn			eg. No.	104	0113	16.
	Physicia		1. Decedent's Name (First, Middle, Last) Robert			Gwin				Date of Deat Month Nuary	Day	Yeer 304	3. Time of Di 01:40	
	/Medic Examin		4a. Fecility Name (If not institution, give str.	eet and number)		4b. City, T	Town, or i	Location of				ty of Deeth	1	
	Examin	er	Crofton Convalesc			Cro	fton				Anne	e Aru	ndel	
1	Funeral Director				yrs. last birthday) Yrs.	If Under	1 Year Days	If Under 2 Hours	Min. J	Date of Birth (Month, Day, Un 14,	1954	9. Birth Cou	place (State or F intry) MD	Foreign
			Usuel Residence of Decedent											
	Marylan f show	lor	10a. State 10b. County MD Anne Arun		. City, Town or Lo Severn	ecation							10d. Inside City 1 ☐ Yes 2	
	with the a or 28a-	Director	10e. Street and Number 8473 New Cut Road			10f. Zip (Code 1144			1	0g. Citizen o		untry?	
	se 23	erai		. Was Decedent Ever	in U.S. 13. 1	Was Decede	ent of His	spanic Orio	nin? (Speci	fv Yes or No-	14. Ra	ace - Amer	ican Indian,	
36	should be filed within 72 hours after death with the Maryland Ind Menial Hygiene. marked other then "netural" or liems 23s or 28s-f show marke event, the Medical Examinar must be redilled at	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		If Yes, speci		Specify:	, Puerto Ri	fy Yes or No- can, etc.)		lack, White cify: Wh		
8	hou	ed	15. Decedent's Educa			dent's Usua					16b. Kind of	Business/I	ndustry	
5	in 72 n "n n "n	piet	(Specify only highest grade	College (1-4or 5+)	(Give	kind of worl DO NOT us	k done di e retired)	uring most	of working					
212	iene r the	Completed	Elementary/Secondary (0-12)	College (1-401 3+)	Fact	tory W	lorke	er			Fibe	rs		
g	illed Hygi other	Be C	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name (First, Middle, I	Maiden Suma	ame)		
<u>a</u>		To B	Claude Gwin					Ma	aria	Pizzol	itto			
ary	should and Men a marke umatic	-	19a. Informant's Name/Relationship (Type							Route Number				
Σ	s 1 and 2 should t Health and Mer Item 27 is marke other traumatic		Mrs. Linda Trimper	/ Sister	3277	01d 1	aney	/town	Road	Westr				
Baltimore, Maryland 21215-0036	Pages 1 arment of Heamont: If Hemury or other		20a. Method of Disposition	- 1	b. Place of Dispo cemetery, crer	osition (Nam	ne of ther place) 1	an 27		20c. Location			
Ë	Pages ment of i		1 ☐ Burial 2 🂢 Cremation 3 ☐ Rei '4 ☐ Donation _5 ☐ Other (Specify)	moval from State	Chesapeal	-		. 10	2004		Steven	svill	e, MD	
H	ニモゼラ .		21. Signature of Funeral Service Licensee								Funera	1 Hom	ne, P.A.	
ã	Depa Impo any ir		Jan Sun	- Moli.						Glen B			21061	
	Physician		23a. Pent Enter the disease, or complications, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the cause on each line.	death. Do not ent	Shin	e of dying	such as	cardiac or r	respiratory arro	est,		Approximate Interval Betwee Onset and De	
	eath certificate be executed attending physician and for use as the burial-transit	cal Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that inhitated events resulting in death) Last d.	Due to (or as a con	nsequence of):	an	e S	is					194	Pans
.O. Box 68	0 0	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pr 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pre					1	Date of deli-		ear .
S, P	8 50	þ	Part II. Other significant conditions cont	nbuting to death but no	t resulting in the u	inderlying ca	ause give	n in Part I.		23e. Did tol	_		the cause of dea	
Ö	w require been si should l	etec	310000							24a, Wasa	241	Wore au	topsy findings av	vailable
of Vital Record		Completed	bysping	101						autops	V	prior to c death?	ompletion of cau	
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	:			04		of Death (Check only on	ne)			
=	Physician: this certific ral director.	ဥ	1 Tes 25 No		2 ER/Outpatier			4 PO NU		9 5 ☐ Reside			cify)	
	ng P liter t	on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time o		8c. Injury Work	?		ld. Describe ho	ow injury occ	urred		
Sio	Attending or death.	cati	2 Accident investigation			М		/es 2 🔲 I						
Division	al or Att s after d il Direct id in by t	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, st. pecify)	reet, factory	, office		28	If. Location (Si City or Town		nber or Ru	ral Route Numb	er,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C		cian: To the best of my er: On the basis of exa and manner stated.										
	To the within 2 To the comple	Me	29b. Signature and title of certifier		4 . 3			number			9d. Date sign	ned (Month	n, Day, Year)	
			Karkesh	anona	MI)	D	20	10	8	1/-	27/C	14	
	1		30. Name and address of person who con			Print)					1			
)		Dr. Rakesh Arora 1				uite	221	Bowie	, MD 2	20715			
	St: Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	don.		÷						

nvaisi	28	State Registrar 1. Decedent's Name (First, Middle, Las			O 44				2. Date of De Month		Year	3. Time of Dea	
hysici: /Medic			Emm	ia G	. Gott				J	an 17, 20	004	2:41 Pm.	
xamin		4a. Facility Name (If not institution, give	·			4b. City, To	own, or l	ocation of De		4c. Cou	nty of Death		
			or Care (Falls R			If Under 1	Vear	If Under 24 H	Iltimore	th.			
neral ector		5. Social Security Number 6. Security Number 212-20-9918 Usual Residence of Decedent	M 2XDF	84	ast birthday) Yrs.		Days	Hours M	in. (Month, Da	y, Year) 1, 1919	Cou	place (State or Fo intry) Md.	
ilied at	ctor	10a. State 10b. County Maryland Anne A	rundel	10c. City	, Town or Loc	cation					10d. Inside City Lim 1 ☐ Yes Ž☐		
at be no	al Dire	10e. Street and Number 8114 Gray Stone Lane				10f. Zip C	ode	21122		10g. Citizen	of What Cou U.S.		
Important, in rein 27 is marked utilet than instituted, or ratios 25s of 26s-1 show any injury or other traumatic event, the Modical Examiner must be notified at 00.08.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			Vas Decede Yes, specif			(Specify Yes or No erto Rican, etc.)	Spec	Race - Ameri Black, White cify:		
Mudical E	Completed	15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12)	ucation	-)	16a. Deced (Give I life. D	ent's Usual kind of work OO NOT use	done du retired)	iring most of v	vorking	16b. Kind of	Business/tr	-	
vant, ins	Ве Сош	12 17. Father's Name (First, Middle, Last)		/	·			Itician 18. Mother's N	lame (First, Middle,		ame)		
umatic e	To	Ernest 19a. Informant's Name/Relationship (7)	1.0000			-			Rural Route Numbe		vn, State, Zij	o Code)	
er tra		Desney Byrd		,				Lane Pa	asadena, Mar				
ry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify)		20b. Pl	ace of Dispos Imetery, crem Arbutu	sition (Name atory or oth S Memo	er place		01/23/04	20c. Locatio	n - City or T Baltimore		
any inju		21. Signature of Funeral Service Licens	tep	,	22.	Name and Este	Address ep Bro	of Facility others Fur	neral Home P Baltimore, M	A. D 21217			
ician dical niner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused ne cause on each line a. Due to (or as a	9. الماليات	textee	r the mode					24	Approximate Interval Betwee Onset and Dea	
he burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	me	ence of):	vance		Jury	nage	(0)			
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detached for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	? ☐ Fetal	death 3□	Ectopic pred Other <i>(spec</i>					Date of deliv Month	ery Day Year	
ا م	d by PI	Part II. Other significant conditions co		t not resu	lting in the un	derlying cau	se giver	in Part I.		ebacco use co ′es 2 □ No		he cause of death pably 4 Hunkr	
al director, page 2 should	Completed									an 24t sy med? 2 No	o. Were auto prior to co death? 1 \(\text{Yes}	opsy findings avai impletion of cause 2 No	
recto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		R/Outpatient	2 D D A	Other	1	eath <i>(Check only o</i> Home 5 Resid		other (Cara)	£.)	
funeral di	ıtlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		28b. Time of Injury		: Injury : Work?	at	28d. Describe h			y)	
completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc.	ry - At hor (Specify)	me, farm, stre	et, factory,	office		28f. Location (S City or Ton		mber or Rura	al Route Number,	
letely fille	Medical (29a. Certifying Phy (Check only one) 2 Medical Exem	sician: To the best of iner: On the basis of and manner stat	examinati	vledge, death on and/or inv	occu rred at estigation, ir	the time	, date and pla nion, death oc	ce, and due to the c curred at the time, o	ause(s) and a date and place	manner as s e, and due to	tated. the cause(s)	
comp	Me	29b. Signature and title of certifier	Dev	_	mD			1469			22/1	4	
					23a) (Type, P		-		7 Inte	-			

ORIGINAL

			1 - For State Registrar	State of Marylar		nent of Health and cate of Death	Reg	ene 200	4 01974
	Dhysisi		Decedent's Name (First, Middle,	Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Hilton	Mable	е	Greene	January	24 200	
7	Examin	-	4a. Facility Name (If not institution,	give street and number)	4b.	City, Town, or Location of De	ath	4c. County of Dea	ath
			ST Agnes He	althrage	B	altimore			
Ŀ	Funeral Director		214-26-1835	3. Sex 7. Age (In yrs. 1 ☐ M 2X) F 74		Under 1 Year If Under 24 Honths Days Hours Mi		^(ear) 29	irthplece (State or Foreign Country) MD
	pus		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Locatio	n			10d. Inside City Limits
	sho	ក	MD Balti		andallst				1 ☐ Yes 2 ☐XNo
	28a-	Director	10e. Street and Number	more in		of, Zip Code	100	. Citizen of What C	Country?
	with the or		3531 Cabot Ro	5.c.		21133		U.S.A	
	ns 23	era	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. Was I	Decedent of Hispanic Origin? , specify Cuban, Mexican, Pue	(Specify Yes or No-	14. Race - Am	nerican Indian,
36	72 hours after death with the Maryland naturel; or Items 23e or 28e-f show idical Examinar must be notified at	by Funerai	1 ☐ Never Married 2 ☐ Marrie **********************************	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		, specify Cuban, Mexican, Pue es 2 <mark>∑</mark> No <i>Specify:</i>	erto Hican, etc.)	Black, Wh	Black
21215-0036	tura stura		15. Decedent's		16a. Decedent's	Usual Occupation	16	b. Kind of Busines	
15	C _ 9	Completed	(Specify only highest	grade completed)	(Give kind life. DO N	of work done during most of w OT use retired)	vorking		,
212	filed within Hygiene. other than "	E O	12th grade	College (1-4or 5+) na	Indust	ry Work		Fact	ory
Maryland 2	ed fall by	Be	17. Father's Name (First, Middle, L.	(Isst)	Jnknown		ame (First, Middle, Ma		
Ž	2 should the and Ment is marked aumatics	^L	19a. Informant's Name/Relationshi	(Tune Print)	19h Mailing Ad	Minery dress (Street and Number or I	ra Johnson		Zin Code)
Ma	12 7 Isa				1-	abot Road, F			21133
	1 at Hea		Denise Iris M	20b. I	Place of Disposition	(Name of		c. Location - City o	
Baltimore,	of of		XXBurial 2 Cremation	Hemoval from State	cemetery, cremator		30/04 E	lkridge,	ма
臣			4 □ Donation 5 □ Other (Special Service Li	****	adow Rio	ne and Address of Facility	0/04 E.	ikriage.	, Mu
Ba	permit. Departr Importa any inje		21. Similar doi 1 dilorar solvico di		Marc	ch F/H West	D-16:	- M -	21215
	195		23a. Part 1. Enter the disease, or c shock, or heart dilure. List o	omplications that caused the des	th_Do not enter the) Wabash Ave	ac or respiratory arrest	ore Ma	21215 Approximate
	ann a sha		shock, or heart valure. List o Immediate Cause (Final	nly one cause on each tine.	0	(36)			Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a Kespicat	ory to	ilure			48 hours
K.	Examiner			Due to (Ar as a consec	Ineuce 2	20000			years
ıç,	© - g	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a cons	uence of):	Disease			7000
	nsit	m	Cause (Disease or injury	Dichotec	Mell	1 to 18			YRAITS
,	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	uence of):				
200		cal		d					
9									
Вох	death certificat e attending phy d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnant 1 Live birth 2 Feta		pic pregnancy		23d. Date of de	,
	0 0	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of c		or (specify)		Month	Day Year
0	at the de by the a tached	hys	9 Unknown	9 Unknown					
S, P	The law requires that the tee has been signed by thoage 2 should be detache	ру Р	Part II. Other significant condition	s contributing to death but not res	sulting in the underly	ring cause given in Part I.			to the cause of death?
ë	w require been sig should b						1 🗆 Yes	2 □ No 3 □ P	robably 4 Unknown
Vital Records,	aw requisible been 2 should	ompieted					24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
æ	The lav	E					performer	d? death?	
ital		BeC	25. Was case referred to medical			26. Place of D	eath (Check only one)		
1	di is	20	examiner? 1 ☐ Yes 2 🕰 No	Hospital: 1 XInpatient 2	ER/Outpatient 3	□ DOA Other: 4 □ Nursing	Home 5 Residence	e 6 □Other (Sp	ecity)
n of			27. Manner of Death 1 ★Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how	injury occurred	
Ö	Attending or death.	atic	2 Accident investiga	tion	N				
Division	or Attendater deat Director: In by the	ertification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ome, farm, street, fa	actory, office	28f. Location (Stree City or Town, S		Rural Route Number,
	ital or A rs after ral Dirs	Cer							
	To the Hospital or Attenwithin 24 hours after deating the Funeral Director: completely filled in by the	edicai		Physician: To the best of my know caminer: On the basis of examina and manner stated.					
	To the within 2. To the I complet	Me	29b. Signature and title of certifier	a MD		29c. License number	29d.	Date signed (Mon	th, Day, Year)
			> & von	WIIID.		P15627	1	2000	4 2004
	X		30. Name and address of person w	no completed cause of death (Iter	n 23a) (Type, Print)		-34	modify of	1 0001
	,	1	Rachel Thomas	110 37 Ac	NES .	900 Caton	Avenue Pr	Ohmare	PEELE OM
-):	Sta	te	31. Date filed (Month) Day Year)	2004 32. Alegistrar's Signa	ature Ass	S.			
1.00	Registr	-		The state of the s	- Maria	As well			

M GREENE

HIL TON

				partment of Health and I		ne 2001. 01076
2	Physic	ian	Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death
	/Medi		MARTIN G. GOETZ		JANUARY 2	
1	Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
		×	GILCHRIST CENTER	TOWSON		BALTIMORE
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		717-12-5045	3,000	9/12/1919	MARYLAND
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation		Table Inside Co. 11 in
	faryl sho	ō		CN ARM		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the A	Director	10e. Street and Number			
	with po a	급		10f. Zip Code		Citizen of What Country?
	eath	era	11701 MANOR ROAD 11. Marital Status 12. Was Decedent Ever in U.S. 13	21057		JSA
	Iten d	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 XYes 2 No	Was Decedent of Hispanic Origin? (SI If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc.
336	irs al	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: WWII	1 ☐ Yes 2 X No Specify:		Specify: WHITE
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f show ite Medical Exercises must be collified at	ed	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16h	Kind of Business/Industry
215	7 oid	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of work DO NOT use retired)	king	Nind of Business/fillustry
2	d with	E	8TH GRADE CAR	PENTER		UNION
	a filed of Hygie other	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maide	on Sumame)
la	should be and Mental s marked o umatic eve	To	JOHN H. GOETZ	MARY C	HYLAND	
Maryland	and h	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rus		or Town, State, Zip Code)
Σ	and 2			1 J.M. PEARCE ROAL		
ore	of He		20a. Method of Disposition 20b. Place of Disp	osition (Name of matory or other place)	_	Location - City or Town, State
Ĕ	Peges nent of I int: If its iry or o		1 M Burial 2 Cremation 3 Removal from State ST. JOHN!	S CEMETERY 1/27	7/2004 HY	DES, MD
altimore,	글 윤란를 .		21. Signature of Funeral Service Licensee	2. Name and Address of Facility THE		
m	Depa Impo any ii		8	521 LOCH RAVEN BLY	D. TOWSON	
			23a Part. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Approximate
	Physician		1	1CER		Interval Between Onset and Death
П	/Medical		disease or condition resulting in death) Due to (or as a consequence of):	TOCK		month
27	Examiner					
	يبد	Jer	Sequentially list conditions, if any, leading to immediate cause. Entry lightl			
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			
o	an ar		resulting in death) Last Due to (or as a consequence of):			
8760	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial transit	Ical	d			
9	ntifica ing ph	Physician/Med	IF FEMALE:			
Box	leath certific attending p	an/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	☐Ectopic pregnancy		23d. Date of delivery
	e dea he at	sici	1 Yes 2 No	Other (specify)		Month Day Year
J.	at the de d by the etached	Phy	9 DOUKHOWN			
Ś,	res thai igned b	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ecords,	w require been si should b	ted	Stroke		1 Tes 2	!□No 3,□Probably 4 □Unknown
Ö	elaw hasb	pie	Atrial febrillation		24a. Was an autopsy	24b. Were autopsy findings available
<u> </u>		Completed			performed?	prior to completion of cause of death?
VItal	sician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	26. Place of Deatl	(Check only one)	
0	Attending Physician: r death. sctor: After this certific by the funeral director.	ို	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	nt 3□ DOA Other: 4□ Nursing Ho	me 5 Residence	6 DOther (Specify) HOSPice
_	ding P h. After t funera	o.:	27. Manner of Death 1 Natural 5 □ Pending (Month, Day Year) 28a. Date of Injury 28b. Time of (Month, Day Year) Injury	28c. Injury at Work?	28d. Describe how inju	
IVISION	Attendil death. ctor: A y the fu	cati	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
₹	or At fter d Sirect	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, str	eet, factory, office	28f. Location (Street as City or Town, State	nd Number or Rural Route Number,
)	urs a					
	Hosp 24 ho Fune Fune tely f	edical	29a. Certifier (Check only one) 1™ Certifying Physician: To the best of my knowledge, deat (Check only one) 1™ Certifying Physician: To the best of my knowledge, deat one of the basis of examination and/or in and manner stated	n occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause(s) and manner as stated.
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Med	one) and manner stated. 29b. Signature and title of certifier			
	F 3 F 8		- 1 11	29c. License number	29d. Da	ite signed (Month, Day, Year)
	X	-	- of prospory lace, me	J. 3.5.5	Jon	spy ad a vor
	10 1		30. Name and address of person (no completed duse of death (Item 23a) (Type,	Prints St. Balto 1	nd 7,7	14
	Sta	0	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1, 17	210	
	Registra		JAN 2 8 2004 Annual Ann	and I		
			JANA U LUUT AMERICAN	1 CAN CONTRACT		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 17 per FH, G827, 01/28/04dhb Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 10:55 PM JANUARY 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth Fecility Name (If not institution, gir Examiner Nion 9. Birthplece (State or Foreign 5. Social Security Number **Funeral** Months Hours 1 XM 2□F Days -134 Director the Maryland 10d. Inside City Limits City, Town or Location 10a. State 10b. County or items 23a or 28a-f show other traumatic event. The Medical Examiner must be notified at **1**Yes 2 □ No more Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
int: If Item 27 Is marked other than "naturel; or Items 23a or 21 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. No 1 Never Married 2 Married ☐Yes Yes, Give 1 ☐ Yes **①** No Baltimore, Maryland 21215-0036 Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) on ary (0-12) Isaac Goodwin Sr. 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Ro Informant's Name/Relationship (Type, Print) Location - City or Town, State thod of Disposition Burial 2 Cremation 3 Removal from State Department of Important: If eny injury or gace. A □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mode of dving. such as cardiac or respiratory arrest Immediate Cause (Final Small Physician cell URans disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be exe the attending physician P.O. Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by page 2 should be 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? res 2 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) luneral dir 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ro the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

JAN 2 8 2004

Lavanya

MD, Union
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yarkagadda

Louke

Memorial

902

Hospital,

20/04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year GILLIS JR KUDOLPH 2004 :30PM 4b. City, Town, or Location of Death c. County of Deeth 4a. Fecility Name (If not institution, give street and number) BHtimora If Under 1 Year If Under 2 TIMES Hecilth 6. Sex 1 M 2 F 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Months 217.24.3396 72 NORTHCARULINA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside Lity Limits 10b. County 1 Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 270le Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuptan, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) STEEL FOREMAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) GILLIS KUBOLPH LENA BROWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 270U DERYL AVE. BATTIMORE, MD 19a. Informant's Name/Relationship (Type, Print) PHVLIS GILLIS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility VAUCHTN C. GREENE FUNDAM HIM 21. Signature of Funeral Service Licenses ORK BOAD BAIT, MORE, MO 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final louis disease or condition resulting in death) Due to (opes a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Hunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Dunknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Unpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred

Records, Physicien: filled in by the funeral Attending death within 24 hours after death To the Funerel Director:

Physician

/Medical

Examiner

10a. State

Funeral

Director

iral, or items 23a or 28a-f ehow Examiner must be natified at

natural

if Health and Mental Hygiene.
Item 27 is marked other than "natu
other traumatic event, in Medical

permit. Pages
Depertment of H
Important: If ite
any injury or of

Enysician

/Medical

Examiner

Examine

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Director

Funeral

þ

Completed

Be

Completed by Physician/Medical Be Medical Certification: To

25. Was case referred to medical examiner? 1 ☐ Yes 2 1 No

4 THomicide

29a. Certifier

27. Manner of Death 1 DiNatural 5 Pending 2 Accident 3 Suicide

investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

12 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of example Uon and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner states. 29b. Signature and title of certifier.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 2004

29c. License number

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

900 alor 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death ecedent's Name (Arg. Middle, Last) Day Yeer hardson **Physician** rarne January 20 2004 /Medical 4c. County of Deeth Town, or Location of Death Examiner YUGBING Home 9. Birthplace (State or Foreign Country) last birthday) 6. Sex **Funeral** 1□M 2**Y**F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10b. County Item 27 is marked other then "natural", or itema 23s or 28s-4 show other traumatic event, the Medical Examinar must be notified at ∰es 2 □ No by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21 ustan s 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 10 No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) Coffege (1-4or 5+) Elementary/Secondary (0-12) ullar 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Maryland and Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mableton GA 30126 nt of Health a:: If Item 27 Is 20c. Lostion - City or Town, State Baltimore, 20a. Method of Disposition
1 Burial 2010 Cremation 3 Removal from State Date permit. Page Department of Important: If any injury or 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) STAGE **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury as the burial-transit that initiated events resulting in death) Last as a consequence of) attending physician by Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably Completed 24a. Was an autopsy performed?
1 Yes 24 t No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No certificate has the Hospital or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 2[] No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DDA 2 ER/Outpatient ဥ 1 Yes this 28d. Describe how injury occurred ineral Director: After thi 28b. Time of 27. Manner of Death

1 Natural

2 Accident Certification: 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier pleted cause of death (Item 23a) (Type, Print) nec 32. Registrar's Signature State Registrar JAN 2 8 2004

DHMH 17 Rev 1/2001

			1 - For Stete Registrar	State of Mary	•	artment of H		nd Mental Hy	giene Reg. No. 2	01979
	Physic		1. Decedent's Name (First, Middle, Last		(-	Green		2. Date of De Month	Day	Year 1515 M
7	/Nedi Exanii		4a. Facility Name (If not institution, give Johns Hopkins K	Say VIEW Me	dical	4b. City, Town, or	Location of I	Death NOTE	4c. County	~~
	Funcal Direcor		218-48-4282	7. Age (In 2M 2□F 57	yrs. last birthday Yrs.	Months Days	If Under 24 Hours	Min. 8. Date of Bir (Month, Da June 1	1, 1946	9. Birthplace (State or Foreign Country) Maryland
	the Maryland	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Balt	imore	. City, Town or L	ocation	Dund	lalk		10d. Inside City Limits 1 ☐ Yes 2ᡯ No
	with the	Director	10e. Street and Number 3425 McShane W	ay		10f. Zip Code	21222		10g. Citizen of V	What Country? d States
36	filed within 72 hours after death with the Maryland Hygiene. ther then "neturel", or Items 23e or 28a-f show	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	in U.S. 13.		ispanic Origin n, Mexican, I Specify:	n? (Specify Yes or No Puerto Rican, etc.)	5- 14. Race Blace Specify	e - American Indian, kk, White, etc.
21215-0036	within 72 hours ine. then "neturel",	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	cation	(Give	edent's Usual Occupa e kind of work done of DO NOT use retired ceelworker	during most o ()	of working		usiness/Industry
Maryland 2	12 should be filed within h and Mental Hygiene. 7 Is marked other then "	To Be Co	12 Years 17. Father's Name (First, Middle, Last) Frederick E. Gree	n	50	Leelworker	18. Mother's	s Name (First, Middle Vera J. Go	, Maiden Sumam	
Mary	nd 2 sho		19a. Informant's Name/Relationship (7) Mrs. Mildred M. G		9			or Rural Route Numb Dundalk,M		State, Zip Code) 21222
ore,	iges 1 and 2 nt of Health if item 27 I		20a. Method of Disposition 1 ABurial 2 Cremation 3 F	Removal from State	-	matory or other plac	-	Date		City or Town, State
Baltimore,	permit. Pages 1 Department of H Importent: If ite		4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service Licens		O Di	of Faith 2.Name and Addres 1da-Ruck I 922 Wise	s of Facility	1/29/2004 l Home of Dundalk, N	Dundalk	, Inc. 21222
	The law requires that the death certificate be executed If he has been signed by the attending physician and If he has been signed by the attending physician and If he has been signed by the attended for the heart of the he	dical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events resulting in death) Last	Acetions that caused the one cause on each line. a. SHO Due to (or as a cor Due to (or as a cor Due to (or as a cor C. Due to (or as a cor	nsequence of):		g, such as ca	ardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
O. Box	he death certif	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pro 1☐Live birth 2☐i 4☐Pregnant at time 9☐Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Dat Mor	te of delivery nth Day Year
rds, P.O.	quires that the signed by the signed by	þ	Part II. Other significent conditions co	ntributing to death but not	t resulting in the t	underlying cause give	en in Part I.		tobacco use contr	ribute to the cause of death?
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Vita	Physicien: Tribis certificat	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital:	2 ER/Outpatie	nt 3□ DOA Othe		of Death (Check only of Death		or (Coorie)
	After	atlon: To	27. Manner of Death 1 SNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time o	of 28c. Injun Work	at at	28d. Describe	how injury occurr	
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp	At home, farm, st	reet, factory, office		28f. Location (City or To		er or Rural Route Number,
	To the Hospitel or within 24 hours afte To the Funeral Dir	Medical		sicien: To the best of my ner: On the basis of exar and manner stated.	mination and/or in	vestigation in my or	ninion death	occurred at the time.	date and place a	and due to the cause(s)
	To the H within 24 To the F	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed	(Month, Day, Year)
	\wedge			Try	(Itam 22=) ~	Peint)	2 000)	1/26	104
	4		30. Name and address of person who of Hoan Tran MD	Manager of death 4940 Ea	SKIN /	Foenue.	Balt	hmore,	MD 21	224
	Sta Re¢st	ate rar	31. Date filed (Month, Day, Year) JAN 2 8 2004	and manner stated. The properties of death 4940 Ea 22. Registrar's S	ignature	&				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4cl County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign MD. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 M 2 F 81 Director 220-07**-**0726 Usual Residence of Decedent 10c. City, Town or Location BALTIMORE the Manyland 10d. Inside City Limits 10a. State 10b. County or 28a-f show BALTIMORE event, the Medical Exercises must be restified at MD 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21209 6534 COPPERFIELD ROAD Iteme 23a Funeral 12. Was Decedent Ever in U.S. Amyed Forces? WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 ŏ Specify: WHITE lf Yes, Giv*e* Year or Dates: þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) than Elementary/Secondary (0-12) ART DEALER of Health and Mental Hygiene. Item 27 is marked other than 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be **GAMSON** LENA EDWARD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6534 COPPERFIELD ROAD BALTIMORE, MD. 21209 MRS. IRMA GAMSON/WIFE 20b. Place of Disposition (Name of ROSEDALE, MD. State 20a. Method of Disposition 1/25/2004 Department of I PETACHY TIKYAHOTONG 1 XBuriai 2 Cremation 3 Removal from State 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 21. Signature of Funeral Service Licensee any ir 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Que to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed Due to (or as a consequence of) use as the burialattending physicien Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 X No 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 1 NInpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel C Hospitel 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifie (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) leted sause of death (Item 23a) (Type/ Print) 30. Name and address of pers P onns 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 8 2004 Registrar

	1	For State Registrar	State of Marylar			nt of He te of D			Reg. No	200	4 0198
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Medic	al -	Angela Lorraine						Januar			
kamin	er	4a. Facility Name (If not institution, give	_				ocation of Deat	th		County of E	
		Holy Cross Hospi 5. Social Security Number 6. Se		last hirthday)		lver S	Spring If Under 24 Hrs	8. Date of B		ontgoi	
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U (O)	-	Usual Residence of Decedent						ψα <u>ι</u>	, ,		
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Jar.	une	11. Marital Status	12. Was Decedent Ever in the Armed Forces?	J.S. 13.	Was Dece If Yes, sp	edent of Hisp ecify Cuban,	Mexican, Puer	Specify Yes or to Rican, etc.)	10-		American Indian, Vhite, etc.
	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 ▼ No If Yes, Give Year or Dates:		1 🗆 Yes	2 X ☐ No	Specify:			Specify:	Black
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	Completed	(Specify only highest grad	de completed)	(Give	kind of w	rork done dui use retired)	ring most of wo	rking	1.55.11		,
	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Soci	al W	orker			Sta	te of	Maryland
1		17. Father's Name (First, Middle, Last)					8. Mother's Na	me (First, Midd			<u> </u>
200	To Be	Joseph Heavens					Annie I	Muskin			
E	F	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Addres	s (Street an		ural Route Num	ber, City o	r Town, Sta	te, Zip Code)
trat		Patricia Heavens-	-Kosh -	126 G	len	Cove I	or., Ch	esterfi	eld.	MO 630	017
otha otha	r	20a. Method of Disposition	20b.	Place of Dispo	sition (Na	ame of		Date	-		or Town, State
0 0	i	1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, crei			emory 1	/31/0/	M + 1	stadt	тт
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9	Ä	resulting in death) Last	Due to (or as a conse	quence of):							
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Tor use as	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet	al death 3		pregnancy				23d. Date of Month	delivery Day Year
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	F.	Part II. Other significant conditions of	setabuting to death but got re	autina in the u	adarkia a	201100 411100	in Part I	23a Dio	t tobacco i	ise contribut	te to the cause of death?
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month TANUARY HAUSE BETTY 10:20 PM **Physician** 2004 /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner HOSPITAL CENTER BALTIMORE n/a HARBOR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Oct. 25 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗓 F 214-26-7477 75 1928 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State r 28a-f show ehow. 1 Yes 2 □ No n/a Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number rel', or iteme 23a or Examiner must be 1526 S. Hanover Street 21230 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white Completed by 3 Widowed 4 Divorced "naturel", f Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Webster Clothes Clerk 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Margaret Samue1 Hunt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1739 Clarkson Street, Baltimore, Md. 21230 Gloria Carper (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of h important: if the eny injury or o once. 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Bayview Crematory 01/24/2004 Baltimore, Md. 21. Signature of Fund I Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A 130 E. Fort ave. Baltimore, Md. 21230 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death RENAL FAILURE mediate Cause (Final ALUIE Brisnik Physician resulting in death) /Medical Due to (or as a consequence of): Imonth SCLERODERMA Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner 2 wills THROMBOCYTEPENIA use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 HEMCLYTIC ANEMIA Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1∐ Yes 2 No or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No Certification: To 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 - Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 94 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Medical Dochos. 30. Name and add as of person who completed cause of death (Item 23a) (Type, Print)

1. In a 10 A L1 SCOI S. HANCYER ST, BALTIMOTE, IND-21225 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar		State of	of Maryla	and / Dep	oartmer e <i>rtifica</i> :			and M	lental Hy	/giene Reg. No	200	Control of the contro	983
	hysicia /Medic Examin	al -	Decedent's Name (First, Midd	n, give s	treet and nu	(C imber)	H		, Town, or	Location of		2. Date of De Month JANUA	Da Ac	y Year 23 200 County of Dea	4 1 1 3	O AM
	ineral rector		5. Social Security Number 185-09-4439 Usual Residence of Decedent	6. Sex 1 ☐	М 2∭Д F		rrs. last birthda 98 Yrs.	y) If Unde Months	r 1 Year Days	If Under	24 Hrs. Min.	8. Date of Bi (Month, D 6-5-19			rthplace (State country) PA	
e Maryland	tified at	ctor	10a. State 10b. County MD Anne		del	i	City, Town or illers v							-		City Limits s 2 No
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.	ns 23e or 26 mast be no	Funeral Director	100. Street and Number 1004 Oakdale			edent Ever i	1 U.S. 13		21		gin? (Spe	ecify Yes or N Rican, etc.)		tizen of What C	USA enican Indian,	
0036	tural', or Ita	þ	1 Never Married 2 Mai 3 Widowed 4 Divorced		Armed Fr 1 Tes If Yes, G Year or D	2 XNo ve		1 Yes, spe	2 🛛 No	Specify:	, Pueno	Hican, etc.)		Black, Wh Specify:	white	
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Maryland 21215-0036 to 2 should be filed within 72 hours aft th and Mental Hyglene.	narked oth	To Be (17. Father's Name (First, Middle Joseph W. Thom 19a. Informant's Name/Relation.	nas	a Print)		10h Ma	iling Address	e (Straat	На	annal		ene I	homas or Town, State,	Zin Code)	
ore, Ma	item 27 le r other traur		Mrs. Louise Hot	ıck	/ daug	201		Oakd	ale (Cir. N	Mille	ersvill Date	e MI		3	
Baltimore, permit. Pages 1 ar Department of Hea	mportant: If iny injury or ince.	I	1 Burial 2 Cremation 4 Donation 5 Other (3	(pecify		State	. Math	ews Ce 22. Name a	emete nd Addres	ry]	y Sir	/2004 ngleton	Fun	ster Sp		PA
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760 Described et	ohysician and the burial-transit	Ical Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b c.	Due to	(or as a cone	sequence of):	•							2-5	,A ,
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	this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1°⊠ Yes 2 □ No 27. Manner of Death	-	ospital: 1 🔼		PER/Outpati		Othe 28c. Injury	9r: 4 □ Nu	rsing Hor	me 5 Resi	idence	6 Other (Spe	ecify)	
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To the Hospital within 24 hours a	To tha Complete	Med	29b. Signature and title of certific	ır .	and mar	iner stated.			c. License	number			29d. Da	te signed (Mon	th, Day, Year)	
1	6		30. Name and address of person	who car	npleted cau	se of death (item 23a) (Typ						0	HAR	BOR HO	SPITAL
F	Sta Registr		31. Date filed (Month, Day, Year		32. F	Registrar's Si	gnatur <i>e</i>	Ly	1.000	Acres 1						

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Physic	cian	Decedent's Name (First, Middle, Las	t)					2. Date of De Month	Day		3. Time of Death 8:10 AM
/Mec		Walter P Heard						sanuary	24	2004	
Exam	iner	4a. Facility Name (If not institution, give	street and number)			, Town, or Location		•		County of Dear	
		Good Samarinan	HOSPITA1	for an A blindburg.	130			O Data of Di		Baltim	
Funera		5. Social Security Number 6. Sec. 216 44 7770	ex 7. Age (In yrs	iast birthday Yrs.	Months		Min.	8. Date of Bi	rth ay, Year)		hplace (State or Foreign buntry)
Directo	r	Usual Residence of Decedent	- 7 7		1			11/15	1.73	7º Mai	ryland
land		10a. State 10b. County	10c. C	ity, Town or L	ocation						10d. Inside City Limits
Many	ō	MD	JA		BALT	IMORE					1 X Yes 2 ☐ No
the 1288	Director	10e. Street and Number			10f. Z	ip Code			10g. Citi:	zen of What Co	ountry?
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death	Funeral	11. Marital Status	12. Was Decedent Ever in t	J.S. 13.	. Was Dec	edent of Hispanic C ecify Cuban, Mexic		city Yes or No	0-	14. Race - Ame Black, Whit	
after of	一臣	1XXNever Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 📉 No If Yes, Give		1 ☐ Yes			noati, oto.,		Specify: AF	
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aryla should and Men marke umatic	2	JOHN DAVIS 19a. Informant's Name/Relationship (7)	HEARD	10h Mai	ling Addro	ss (Street and Num					Zin Code)
2 6 2 9	1	TARA R. HEARD (1		3318	•	NORTHERN					21206
		20a. Method of Disposition		 Place of Disc	position (N	ame of		ate		cation - City or	Town, State
O 8° = 5		1 XBurial 2 ☐ Cremation 3 ☐		cemetery, cr			1 /21 /	04	D A STE		UNI MIN
altim mit. Pa partmen portent:		' 4 □ Donation 5 □ Other (Specify 21. Signature Funeral Septice Licen				L PARK and Address of Fac	1/31/			DALLSTO L HOME	
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T.		shock, or heart failure. List only Immediate Cause (Final	one causa on each line.								Interval Between Onset and Death
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68 iticat g phy as th	_										
Box 68 leath certitics attending pt	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fel		□Ectopic	prognancy			2	23d. Date of de	•
death death	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of		Other (Month	Day Year
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Records, he law requires t e has been signe	ed	HANY (05119	Spondyli	115.				10	Yes 2.	ZNo 3□Pi	obably 4 Unknown
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of V Physica this ce	ToE	examiner? 1 🗆 Yes 2 🛣 No	Hospital: 1 ■ Inpatient 2 [ER/Outpation	ent 3 🗆 🛭	OOA Other: 4	Nursing Hor	me 5□Res	idence 6	G □Other (Spe	city)
on of Vital Red ding Physicien: The lav h. Atter this certilicate has funeral director, page 2		27. Manner of Death 1 XNatural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury		28c. Injury at Work?		28d. Describe	how injur	y occurred	
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To the within 2 To the Complet	Medical	one) 29b. Signature and title of certifier	and manner stated.		2	9c. License numbe	er		29d. Dat	e signed (Mont	h, Day, Year)
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3)	Tole		- 00 \ -	- 0-1-11	10)			٥٧	01 · 2m · 1	. 0 -/
0		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type	Ral	mn R1.11	1 R-	16:1	s ^-	MM	21239
	State	31. Date filed (Month Oldy, Deal)	nna 32 egistrar's Sigr	nature	1 40	CI ISLUC	. 17 (11 4 000	ore,	VV	~1~>)
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	• 92		1. Decedent's Name (First, Middle, La	st)					2. Date of D	eath		3. Time of Death
	Physic		Roatrico	E. H	are	210			Month	24	y Year 2004	6,25 PM
	/Medi Examir		4e. Fecility Name (If not institution, give			-	c. City, Town, o	Location of De	ath		County of Death	1
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	p .		Usuel Residence of Decedent 10a, State 10b, County		100 City	Ya						
	aryla ehov	-	Toa. State Too. County			Town or Locati						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
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	with t	Funeral Director	10e. Street and Number	4 / /			10f. Zip Code				izen of What Cou	ntry?
	ath v	rai	2529 Mentucky	AVE			21213				54	
	er de Itam	une	11. Marital Status	12. Was Decedent Armed Forces	?	13. Was	Decedent of H s, specify Cuba	lispanic Origin? an, Mexican, Pue	(Specify Yes or Nerto Rican, etc.)	0-	 Race - Americ Black, White, 	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	110	10	Yes 2 → No	Specify:			Specify: A	
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or itams 23a or 28a-f show event, the Medical Exercites trausite trivilled at	edt	15. Decedent's Ed			16a Decedent	's Usual Occup	ation		16h K	D/A	
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lan		To B	Eddie RobINSON					9,55,5	dee			
Maryland	d 2 should th and Mer 7 is marke traumatic	-	19a. Informant's Name/Relationship (ype, Print)		19b. Mailing A	ddress (Street		Rural Route Numb	er, City o	r Town, State, Zin	Code)
	nd 2 alth a 27 is		LISA CRENSHAW						Himore, 14			,
Baltimore,	s 1 and if Health itam 27 other tr		20a. Method of Disposition		20b. Plac	e of Disposition	n (Name of ary or other place		Date		cation - City or To	own, Stete
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			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that cause	d the death.	Do not enter th	e mode of dyin	g, such as cardi	ac or respiratory	rrest.	3 40 616	Approximate
760	Medical Examine Assician and As	ical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c. Due to (or as d.	<u> </u>	ice of).						
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Records, P	8 5 8		Part II. Other significant conditions of Pancy to pan		out not resultin	ng in the under	lying cause give	an in Part I.	11	tobacco u Yes 2[_	e cause of death?
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Divis	P jr E	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj	ury - At home c. (Specify)	o, farm, street,	factory, office		28f. Location (City or To	Street and wn, State)	d Number or Rura	Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical (29a. Certifier (Check only one) 1 ✓ Certifying Phy 2 ☐ Medical Exam	rsicien: To the best iner: On the basis o and manner st	t examination	dge, death occ and/or investi	curred at the tim gation, in my op	e, date and plac pinion, death occ	e, and due to the curred at the time,	cause(s) date and	and manner as st place, and due to	ated. the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	17. "			29c. License	number		29d. Date	signed (Month, L	Day, Year)
)			Kam Din	Ris	mi)	10 1	6914			-	
	i		30. Name and address of person who o	ompleted cause of c	leath (Item 23	a) (Type Print) J	0111		Jul	1,27,	X004
	φ		DmitRy Dine 31. Date filed (Month, Day, Year)	Cis 560		4 Rai	en Bo	LOVERCE	, Balt.	MOR	O MO	2004
	Sta Registr	_	JAN 2 8 2		ars signature	B	Spark	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Ethel R. Harvey Jan. 2004 6:35 a /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Charlestown Retirement Center Catonsville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Nonths | Days | Hours | Min. | Dec. | 18, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Year 1□M 2√F 219-38-9554 1915 Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State or Items 23s or 28s-1 show the Medical Examiner must be notified at 1 Yes 2 No Md. Baltimore White Hall Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2417 Garrett Rd. 21161 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: If Yes, Give Year or Dates: Specify: White 3 ☐Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If itsm 27 is marked other than "ns any injury or other traumatic event, the Medic once. College (1-4or 5+) Elementary/Secondary (0-12) Public Schools Registered Nurse 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Frederick O. Seyter Florence L. Eppers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan R. Warnsmann - Daughter 2417 Garrett Rd., White Hall, Md. 21161 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Mem. Park Jan. 29,200 Sykesville, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 21. Signature of Funeral Service Ligengee 21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician weeks Preumonio
Due to (or as a consequence of): resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy funeral director, page 2 should be detached for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď 3 Probably 4 Unknown coronary 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 🗌 Yes Sich 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 🗌 Yes 2 ∏No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 | Homicide within 24 hours after To the Funeral Dire Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0030989 address of person who completed cause of death (Item 23a) (Type, Print) 711 Maiden Choice Ln Catonsville MD MD. 32 Registrar's Signature State Registrar

			, rui	partment of Health and Mertificate of Death	lental Hygie	
ď		:	Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year 3. Time of Death
No.	Physici /Medio		Elmer C. Jones Sr.		January	23 2004 5:15 A ^M
1	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
		-p 2x	105 Highland Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Glen Burnie	C. Data of Birth	Anne Arundel
o·	Funeral Director		213-18-6221 1 XM 2 F 83 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye July 12	9. Birthplace (State or Foreign Country) 1920 MD
	p.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or			
	shov	'n				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-f	Director	Maryland Anne Arundel	Glen Burnie	10a.	Citizen of What Country?
	3a or	0	105 highland Road	21060		USA
	death	Funeral		B. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or liems 23a or 28a-f show imatic event, the Medical East, in at treat the modified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☒ No Specify:	110411, 510.)	Specify: White
Maryland 21215-0036	tural'	ed p	3 X Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Dec	edent's Usual Occupation	166	. Kind of Business/Industry
215	hin 72 in "ne Me Als	Completed	(Specify only highest grade completed) (Giv	re kind of work done during most of worki DO NOT use retired)	ng	,
2	filed wit Hygiene Athar tha	Com	8	Plumber		Residential
n	tal Hy doth	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Maid	
<u>\S</u>	hould d Men narke natic	ဥ	William Lee Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	Anna iling Address (Street and Number or Rura	Haig	·
S	nd 2 s ith an 27 is u	I		9 Parkway Drive, Ba		
ē,	es 1 and 2 should b of Heath and Ment f Item 27 is marked r othar traumatic e		20a. Method of Disposition 20b. Place of Dis	position (Name of ematory or other place)	^{20c}	. Location - City or Town, State
altimore,	Pages nent of I ant: if its		1 District 2 Cremation 3 Removal from State		The state of the s	ownsville, Maryland
Balti	permit. Pages Department of Important: ff It any injury or o		21. Signature of the al Service Light see	22. Name and Address of Facility		Funeral Home, P.A.
E/SE.	1 m		23a. Part 1. Enter the clisease, or complications that paused the death. Do not e shock, or heart failure. List only one cause on each line.	3111_Mountain_Roac nter the mode of dying, such as cardiac o	recoratory arrest	Approximate
5	Physician		Immediate Cause (Final disease or condition	IL CHREINOMA	of The	Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):			00000
	Examiner	_	Sequentially list conditions, if any, leading to immediate b			
	ted	nine	cause. Enter Undertying Cause (Disease or injury			
<u>,</u>	execu n and ial-tra	Examin	that initiated events resulting in death) Last c. Due to (or as a consequence of):			
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မ	artifica ing ph e as th	Med	IF FEMALE:			
â	ath ce	ian/	23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3	☐Ectopic pregnancy		23d. Date of delivery Month Day Year
o.	that the death certifued by the attending to detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5	Other (specify)		
Vital Records, P.O. Box	The law requires that the death certifi tle has been signed by the attending i age 2 should be detached for use as	y Pt	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
rds	w require been sig should b	ed b	HYPERTENSIVE HEART DISEAS	· E	1 □ Yes	2 No 3 Probably 4 Unknown
ဝင္ပ	ne law re has beo ge 2 sho	Completed by	CORODARY ARTERY DISE	4SE	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
œ.		Com	\		performed	? death?
Vita	iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death		
ot		To	1 Yes 2 No 10 Inpatient 2 ER/Outpate 27. Manger of Death 28a. Date of Injury 28b. Time	ent 3 DOA 4 Nursing Hor	ne 5 Nesidence 28d. Describe how in	6 Other (Specify)
on	nding tth. :: Afte e fune	atior	Maturał 5 ☐ Pending (Month, Day Yeer) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		, ,
Division of	r Attar er dea rector by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number,
ō	ital or rrs aft ral Di					
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, der only one)	ath occurred at the time, date and place, a investigation, in my opinion, death occurred	and due to the cause ad at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To th withir To th comp	Me	296 Signature and hite of centifier	29c. License number	29d.	Date signed (Month, Dey, Year)
	,		1/ Aug Com	202585	0	123 2004
×	1		30. Name and address of person who completed cause of death (Item 23a) (Type			
1)	Sta	to.	Attastacio Suhong, M.D. 206 Crain Hig 31. Date filed (Month, Day, Year) 32. Registrar's Signature	hway, Glan Burnie,	MD 21061	
	Registr		JAN 2 8 2004 Janes &	Anaste 1		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 2 Oate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 19 04**Physician** 3:05p. M Johnson January D. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Overlea Manor Nursing Home Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**⊠** M 2□ F 81 Yrs. **Director** 218-14-7245 MD 12 05 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location rthan "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at XXYes 2 No Baltimore Director MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 U.S.A. 3927 Annellen Road 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, etc. 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2X Marned Specify: Black 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry entary/Secondary (0-12) College (1-4or 5+)
na other than Balto City Schools 12th grade Supervisor permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other only injury or other traumatic event, 9068. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sarah Robinson Ernest Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3927 Annellen Road, Baltimore Md Margaret Johnson-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removat from State * 4 □ Donation 5 □ Other (Specify) King Memorial Park 1/27/04 Randallstown, Md 21. Signature of Funeral Service(t 22. Name and Address of Facility
March F/H West 21215 4300 Wabash Ave, Baltimore Md 23a. Pag 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Orset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** nomo /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or intury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed hed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 0
9 Unknown Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes peen : 24a. Was an autopsy performed 1 ☐ Yes 2 24b. Were autopsy findings available prior to completion of cause of death? has 2□ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one Other: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury a Work? completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No investigation Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours af To the Funeral D 29a. Certifier critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type-Print) - LOCK Kaven Blva 31. Date filed (MoA Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of Mary		artment of H			ene 2 0	04	01989
			1. Decedent's Name (First, Middle, L.	ast)				2. Date of Death		Marin .	3. Time of Death
	Physici /Medio		Bernice	Chase	e	Johr	nson	Month	Day	Year Zoo'4	12:00PM
	Examin		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or	Location of Deat	h	4c. County	of Death	
О			Union Memoria	1 Hospital		Baltimo	ore				
	Funeral				yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		(ear)	9. Birthp Coun	ace (State or Foreign
	Director		210-22-4703	1□ M X (X) 88	B Yrs.			11 07	15		MD
	pur M		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	cation				11	Od. Inside City Limits
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	28a-	ect	MD NA 10e. Street and Number	1	3altimo	10f. Zip Code		100	. Citizen of V	What Coup	••
	death with the Maryland ims 23s or 28s-f show	Funeral Director	1331 North Woo	dyear Stree	<u> </u>		217			5 • A •	.,.
	ns 23	era	11. Marital Status	12. Was Decedent Ever				Specify Yes or No-	7	e - Americ	an Indian.
(0	r itar	Fun	XX Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X No		Was Decedent of His f Yes, specify Cubar		to Rican, etc.)	Blac	k, White,	etc.
8	al', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes X No	Specify:		Specify		ack
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2	thin and	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired)		i king	D		
2	filed within 72 hours after Hygiene. other than "natural", or ita ent, the Medical Exemine	Cor	8th grade	na	Dom	estic Wo			Priv		
P L	tal H d oth	Be	17. Father's Name (First, Middle, Las	<i>t)</i>				me (First, Middle, Ma	iden Sumam	e)	
yla	should and Men a marke umatic	2	Frank Chase					Castor			
Лаг	2 sh and is m	1	19a. Informant's Name/Relationship	•				ural Route Number, C			
e,	is 1 and 2 of Health ar item 27 is other trac		Marlene Brown 20a. Method of Disposition		Db. Place of Dispo		at Stre	et, Balt			21217
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any figury or other traumatic svent, the Medical Examiner must be notified at once.		1 Burial 2 □ Cremation 3 ['4 □ Donation 5 □ Other (Special S	Removal from State	cemetery, cren	natory or other place	· 1		c. Location -		
Ħ	it. Partitudes reported in the second in the		*4 □ Donation 5 □ Other (Special Signature of Funeral Service Lies	A				1/30/04	Arbu	ıtus	Md
Ba	permit. Departn Imports any inju		Hahaa Q	2 h	M	Name and Address	West	D-164		a 3 .	21015
		0	23a, Part1, Enter the disease, or con	folications that carried the				Baltin		ia .	21215 Approximate
CSQ.			23a. Part1. Enter the disease, for conshock, or heart failure. List only						,		Interval Between Onset and Death
#8 -2	Physician /Medical		disease or condition resulting in death)	a. Tetast Due to (or as a con	and Pi	ancrea	ric Co	mcer			15 days
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o,	e exe ien al urial-t	EX	resulting in death) Last	Due to (or as a con	sequence of):						
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<u> </u>	ing p	Mec	IF FEMALE:								-
Вох	eath certific attending p	ian/	23b. Was decedent pregnant	23c. If yes, outcome of pre	Fetal death 3	Ectopic pregnancy			23d. Date Mon	of deliver	y Day Year
o o	the a	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown	4☐Pregnant at time 9☐ Unknown	of death 5	Other (specify)					July 1 July 1
Р. О.	that the de	P	Part II. Other significant conditions	contributing to death but not	resulting in the un	nderlying cause give	n in Part I	23e Did tohac	co use contri	ibute to the	cause of death?
ds,	signed d be del	d by			•	,			_	3 🗀 Proba	3.7
Š	w require been si should I	ete						-	1		
Re	has has ge 2	Completed						24a. Was an autopsy	9	rere autop rior to com eath?	sy findings available pletion of cause of
ā	ician: The l certificate ha	င္ပ	25. Was case referred to medical					performed 1 ☐ Yes 2 ☐	No 1	☐ Yes	No
Division of Vital Records,	ysician: is certific director,	o Be	examiner?	Hospital: 1 Inpatient	2 🗍 ER/Outpatient	Othor		th (Check only one)	- Mariant - Anna	11115-	
o	Phys or this eral di	\vdash	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury Work	4 Nursing H	ome 5 Residenc 28d. Describe how			
0	ttending P death. tor: After I the funera	Ē	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Yea	r) Injury		es 2 No				
N N	f or Attendia after death. Director: A I in by the fu	Hice	3 ☐ Suicide 6 ☐ Could not b	200. Place of Injury - A	At home, farm, stre	eet, factory, office		28f. Location (Stree	t and Numbe	r or Rurai	Route Number,
ā	s after s Direct sed in by	Certification:	4 Homicide	building, etc. (Sp	ecity)			City or Town, S	rafe)		
	To the Hospitel or Attending Physicien: The law requires that the death certific thin 24 hours after death. To the Funeriel Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying Pl	nysician: To the best of my	knowledge, death	occurred at the time	, date and place	, and due to the caus	e(s) and mar	ner as sta	ted.
	the H nin 24 the F plete	Medical	51107	miner: On the basis of exam and manner stated.	mation and/or inv			iled at the time, date	and place, a	na due to	ne cause(s)
	To To	2	29b. Signature and title of certifier	rure, M.D		29c. License			Date signed		
							38946	5-1545	Janu	ary	25,2004
	5		30. Name and address of person who				clot.		2	1-0-	
			OMAR HAM 2 31. Date filed (Month, Day, Year)	32 Benificar's S			· UNION	MEMOR	1421	10>1	IFAL
10	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 8	2004	Age	Sient "					

			For Stete Registrer	State of Maryla		epartment of H Certificate of L			ene g. No. 2004	01990
	Physicia		 Decedent's Name (First, Middle, La Jean 	st)		Jones		2. Date of Death Month January	Dav Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, given University Hospi			4b. City, Town, or Baltimo	Location of Death		4c. County of Death	
	Funeral Director		215-14-8291	6ex 1□M 2√2F 7. Age (In y	rs. last birthe Yr	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 11–28–		place (State or Foreign htry)
	ow ot		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town	or Location			1	0d. Inside City Limits
	a-f sh	ctor	Md. NA		Bal	timore				1 X Yes 2 □ No
	or 28	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cour	ntry?
	eath v	erai	1613 N. Hilton A	Ve. 12. Was Decedent Ever ii	n U.S.	212. 13. Was Decedent of Hi	ispanic Origin? (Spe	ecify Yes or No-	USA 14. Race - Americ	ean Indian,
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Itama 23a or 28a-f show of other than "natural", or Itama 23a or 28a-f show event, the Medical Evariatinal must be notified at	by Funeral Director	1 Never Married 2 Married 3√2 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No It Yes, Give Year or Dates:		It Yes, specify Cuba	n, Mexican, Puerto Specify:	Rican, etc.)	Specify: Bla	
2-0	72 hou	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	(1	ecedent's Usual Occupa Give kind of work done of	during most of work	ing 1	6b. Kind of Business/In	dustry
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and	be filed stal Hygie od other	Be	17. Father's Name (First, Middle, Last	r) Fedd	7		18. Mother's Name Novel		laiden Surname) Hill	
Maryland	s 1 and 2 should be if Health and Menta itam 27 is merked other traumatic ev	2	Willie 19a. Informant's Name/Relationship			Mailing Address (Street a				Code)
	s 1 and 2 s f Health ar ftem 27 is other trau		Karen Stokes	Niece	13	48 Silverth	orne Rd.,	Baltimo	ore, Md.	21239
Baltimore,	of Hea of Hea Hitam or othe		20a. Method of Disposition 1 🛱 Burial 2 ☐ Cremation 3 [b. Place of D cemetery,	isposition (Name of crematory or other place		Date 2	Oc. Location - City or To	own, State
ţ	t. Pag riment rtant: njury c	3	` 4 ☐Donation 5 ☐ Other (Speci	(fy)	Mt.	Zion Cem. 22. Name and Addres	1-28		Lansdowne,	
Bal	permit. Pages : Department of the important: If ite any injury or of once.		21. Signature of Funeral Service Lice 23a. Pent1. Enter the disease, or con	Wane		March F.H.	East	1101 E.	imore, Md. North Ave	21202 Approximate
8760°	/Medical Examiner	dicai Examiner	shock, or heart tailure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	sequence of	eron-cosdian	10		790 0	Interval Between Onset and Death
.O. Box 68	death certifications attending at for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delive Month	ery Day Year
<u>α</u>	uires that the signed by the detaction is detacted by the detaction is a signed by the detacted is a signed by the	by	Part II. Other significant conditions	contributing to death but not	_	he underlying cause give	en in Part I.		acco use contribute to the	1.00
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/ita	Physician: 1 this certificar ral director, p	BeC	25. Was case referred to medical examiner?	Hospital:		Otho		(Check only one		
of	Phys this al dir	. To	1 Xres 2 No 27. Manner of Death	1 (XInpatient 28a. Date of Injury	2 ER/Outp 28b. Tir		4 🗆 Nursing no	me 5 Resider	nce 6 Other (Specification of the first of t	y)
ion	Attending I r death. ector: After by the funer	ation	1 □ Natural 5 □ Pending 2 ☑ Accident investigate	(Month, Day Yea	(r)	SPM 10	k? Yes 2 No		CothoteRp	bacement
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	e Hospital or 24 hours afte e Funeral Dire letely filled in b	edical ((Check only 2 Medical Exa	hysician: To the best of my miner: On the basis of exam						
	To the Hospital or within 24 hours affer To the Funeral Dir completely filled in	Med	29b. Signature and title of cedifier	and manner stated.		29c. License	e number	29	d. Date signed (Month,	Day, Year)
	⊢ ≤ ⊢ ō		Paris	_ Paloe	- mo	O.C.M	1.E.		January 22,	2004
	2		() 1 //	completed cause of death (2	ype, Print)				
	Sta	ito	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	1 Penn Stre	et, Balt	imore, Ma	aryland 212	01
	Regist		JAN 2 8 20			I how to				

		riease						-	Are Legible.	•
		1 - For State Registrar	State of N	viaryland		artment of F <i>tificate of</i>		Mental Hy	2001	+ 01991
		Decedent's Name (First, Middle, L.)	ast)			incate of	Death	2. Date of De		3. Time of Death
Physic /Med		Lillian Estell	e Kloch					January	Day Year 2004	
Exam		4a. Facility Name (If not institution, g	ive street and numbe	or)		4b. City, Town, o	r Location of De		4c. County of De	
		Genesis Eldercare				Severna			Anne Aru	
Funera Directo			.Sex 7. A 1 □ M 2√2 F	Age (In yrs. Ias 87	t birthday) Yrs.	Months Days	If Under 24 H Hours M	n (Month Da	9. Bi	inthplece (State or Foreign
		219-22-0270 Usual Residence of Decedent						August	22,1916 Ma	ryland
anylan show	_	10a. State 10b. County		10c. City, 1						10d. Inside City Limits
he Mi	Director	Maryland Anne Aru	inde1	Seve	erna I					1 ☐ Yes 21 No
with	급	512 Likeston Cour	c+			10f. Zip Code 21146			10g. Citizen of What C	
deeth ms 23	Jera	11. Marital Status	12. Was Deceden		13. \		lispanic Origin?	(Specify Yes or No- arto Rican, etc.)	United Sta	
after or it.	by Funerai	1 Never Married 2 Married	Armed Forces 1 ☐ Yes 2 X If Yes, Give			Yes, specify Cuba		erto Rican, etc.)		
003		3 N Widowed 4 □ Divorced	Year or Dates				Specify:		Specify: Wh	nite
Iryland 21215-0036 should be filed within 72 hours after deeth with the Maryland to Mental Hygiene. marked other then "natural, or items 23a or 28e-f show matic event, the Medical Examination matter and lifed at	Completed	15. Decedent's (Specify only highest g	rade completed)		(Give	ent's Usual Occup kind of work done OO NOT use retired	during most of w	vorking	16b. Kind of Busines:	s/Industry
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aryland should be and Mental marked o	2	Mervin Catterton						n Hershey		
0 2 a a a		19a. Informant's Name/Relationship Mary F. Steinhice							r, City or Town, State,	
Te, N 1 and Health Health Ther tr		20a. Method of Disposition	: - uaugnte			Sition (Name of patory or other place		Date Date	ark, Maryla 20c. Location - City o	
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Baltimol permit. Pages Department of Important: If II any injury or once.		21. Signature of Funeral Service Lic		Loud	22	Name and Address	ery 1/2 ss of Facility H	28/2004 ubbard Fu	Baltimore, neral Home	Maryland . Inc.
Depa Depa Impo	4. 9	1 Unn 4.3	ink						more, Mary	
Đ.		23a. Part1. Enter the disease or con shock, or heart failure. List on	plications that cause one cause on each	ed the death. [Do not ente	r the mode of dyin	g, such as cardi	ac or respiratory arr	est.	Approximate Interval Between
Physician	_	Immediate Cause (Final disease or condition	_a Cer	ebro	gras	culor	ac	cident		Ons t and Death
/Medical Examiner		resulting in death)	Due to (or a	is a consequen						
W 4	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a consequen	ce of):					
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BOX 68, eath certificate attending phy	by Physician/Med	IF FEMALE:	23c. If yes, outcome	e of pregnancy	,					
BOX death cer attendin	cian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth	2 Fetal de at time of death	ath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
at the contraction of the contra	hys	9 Unknown	9□ Unknown			(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
- F & A	by P	Part II. Other significant conditions	contributing to death I	but not resultin	g in the un	derlying cause give	en in Part I.	23e. Did to	pacco use contribute to	the cause of death?
COTGS, w requires t been signe should be	ted							1 🗆 Y	es 2□No 3□P	robably 4 Unknown
e law has b	Completed							24a. Was a autops	y prior to	utopsy findings available completion of cause of
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	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 △ No	Hospital:	ient 2□ER/	Outpations	3D DOA Othe		ath Check only on	7	
g Physical this seral di	n: T	27. Manne of Death	28a. Date of Inju	iury 281	b. Time of	28c. Injury Work	at		ence 6 Other (Spe	cify)
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UNISION or Attending after death. Director: Afte	Certific	3 Suicide 6 Could not l 4 Homicide determined	286. Place of in	njury - At home atc. <i>(Specify)</i>	, farm, strø	et, factory, office		28f. Location (St City or Town	reet and Number or Ri o, State)	ural Route Number,
pitel ours a ierel [29a. Certifier 1 Certifying P	busicies: To the best	t of my knowled	dae deeth					
DIVISION OF To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Exa	miner: On the basis of and manner st	or examination	and/or inve	estigation, in my op	e, date and place pinion, death occ	e, and due to the ca urred at the time, da	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
To th Vithir To th	Me	29b. Signature and title of certifier	1 1 -	N	11)	29c. License	number	2	9d. Date signed (Mont	h, Day, Year)
62						1) 5	072	5	1-27	7-2004
3		30. Name and address of person who	completed cause of	death (Item 23:	a) (Type, F	rint)	14.	1. 100 1	lersville	Max
	ate	31. Date filed (Month, Day, Year)	ectinger Reniet	trar's Signature	1/ 1	elera	ns/su	41010	ursville	1011
Regist		IAN 2 8 200	A	is the said	4	house				XIICO

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 4 Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death **Physician** 7 COU 37 anes 001 22 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Locetion of Death 4c. County of Death Ridgeway Manor Nursing Home Catonsville Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□ M 2□ F Months 214-38-3232 Director 64 Yrs. 2/16/1939 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ ... any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Baltimore Catonsville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 241 Blakeney Rd. Funeral 21228 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 22 Married 1 ☐ Yes 2 Z No Specify: ģ 3 Widowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Technical Associate Research 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert B. Kernan Mary L. Bates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jo Ann Kernan - Wife 241 Blakeney Rd. Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park 1/26/04 Elkridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Home of Catonsville 1630 Edmondson Ave. Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Hetartatic long carcinoma 1-2 none Examiner Due to (or as a consequence of): Physician/Medical Examiner attending physician end for use es the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? signed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 2 page 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? peen this certificate has 1 Tyes 2 Tillion 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Universing Home 5 Residence 6 Other (Specify) ۵ 1 Yes 2 No 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death Certification: 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ∏Yes 2 ∏No 6 Could not be determined 3
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) beliese (every 019667 01-22-20:04 O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Schwartz 7310 Ritchie Highway Glen Burnie, Maryland 21061

32. Registrar's Signature

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

JAN 2 8 2004

			. For	State of Ma							ental Hyg	giene	001	01000
_			State Registrar			Cer	tificate	e of L	Death				004	01993
	Physici	an	Decedent's Name (First, Middle, Last)								2. Date of Dea Month	Day	Year	3. Time of Death
A-C.	/Medic	al	Lois Marguerite 4a. Facility Name (If not institution, give s		<u>i</u>		4b Cibr	Tour or	Location o		January		ZUU4 unty of Death	4:20 A.M
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	Funeral		5. Social Security Number 6. Sex	7. Age	e (In yrs. I	last birthday)	If Under	1 Year	If Under		8. Date of Birtl (Month, Day			lace (State or Foreign
	Director		214-14-7018	м 2X0F 9	1	Yrs.	Months	Days	Hours	Min.	Jan. 31	, 191	2 Mar	yland
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	d within 72 hours after death with the Maryland jiene. r then "naturel", or Items 23a or 28a-f show the Medical Examinar must be notified at	ō	Maryland Baltimore	2		tonsvi								1 ☐ Yes 2 No
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	ems ;	Funeral	11. Marital Status	2. Was Decedent I Armed Forces?	Ever in U.	S. 13. \	Was Deced f Yes, spec	ent of Hi	spanic Orig	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)	14. [Race - Americ Black, White,	
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Maryland 21215-0036	hour	ed b	15. Decedent's Educ	Year or Dates:		16a. Deced	lent's Usua	I Occupa	ition			16b. Kind o	Whi of Business/Inc	
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45	an ealt m 2		20a. Method of Disposition	ugneer	20b. P	lace of Dispo			-		ate		on - City or To	
20	ages ant of it: If II y or c		1 Burial 2 □ Cremation 3 □R 14 □ Donation 5 □ Other (Specify)	emoval from State	- 1	_{emetery, cren} udon P			- 1	/26/0	14	Balti	more.	Maryland
Baltimore,	permit. Pages 1 Department of H Importent: If Ite eny injury or ott		21. Signature of Funeral Service License	000		_ 22	. Name an	d_Addres	s of Facilit	v				
ä	\$ 0 E 8		2 fragit	LVX.		16	30 Ed	lmond	lson /	Aveni	ie: Cat	onsvil	Lle, Ma	ryland 2122
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Ш	D =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	uence of):								
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<u>></u>	ding Physiclen: The I n. After this certificate ha funeral director, page	ို	To tes ZIAINO	lospital: 1 Inpatie		ER/Outpatien		-	4 🗀 Nu	-	me 5 V esid			y)
		lon	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	M	8c. Injury Work	rat t? Yes 2 ∐i		28d. Describe h	ow injury oc	currea	
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ŀ		Σ	29b. Signature and title of certified	Mu 1	w		290	License	number 202	09	ad at the time, of	29d. Date si	gned (Month,	Day, Year)
	18		30. Name and address of person who co	mpleted cause of d	leath (Iten	n 23a) (Турө, Мац	Print)	Ci	ine	el	any	Can	tour	nlle
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JAN 2 8 20	32. Registr	ar's Signa	iture	and a	,					MI	12118

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 9:30 Am JANUARY KEENE ARGARET 25 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Neme (If not institution, give street and number) Examiner Forest Haven Nursing Home CATONSVILLE BALTIMORE 8. Date of Birth (Month, Day, Year) 9. Birthplace (Sta Country) March 19,1916 Maryland If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours Months Days 1 □ M 2 🖸 F 85 212-36-2867 Director Usuel Residence of Decedent filed within 72 hours after daath with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County thems 23a or 28a-f show ner must be notified at 1 ☐ Yes 2 🛣 No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 314 Osborne Avenue 21228 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 21215-0020 ŏ 1 Yes 2 No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medical Secretary Bon Secour Hospital Pages 1 and 2 should be filed nent of Health and Mental Hygi Int: If Item 27 Is marked other Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Travers Delia A. Casserly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Husband) 314 Osborne Avenue Catonsville, Maryland 21228 Jennings M. Keene, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Lakeview Memorial Park 1-30-04 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lices 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical 214-IMERO Examiner Physician/Medical Examiner To the Mospital or Attending Physician: The law requiras that tha death certificate ba axecuted within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the attanding physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 45 Unknown 1 ☐ Yes 2 ☐ No 3 Probably ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 Yes 2 HNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) nem 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) HEIGHTS AVE, BALD MD 21208 7220 31. Date filed (Month, Day, Year) 32. Begistrer's Signature State JAN 28 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

DHMH 17 Rev 1/2001

	. 1	For State Registrar	State of Ivial	yland / Depa <i>Cer</i>	tificate of L			eg. No. 20	04	0199
Physicia	ın	Decedent's Name (First, Middle, Last) Eugene		Keato	n		2. Date of Deat Month	Day	Year 004	3. Time of Death
/Medica Examine		4e. Fecility Neme (If not institution, give support of the Union Mem. Hosp.	street and number)		4b. City, Town, or	Location of Death		4c. County o	of Death	
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. lest birthday) 9 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, 1–12–1	, Year) 5	9. Birthpla Country N.C	ce (State or Fore
show		Usual Residence of Decedent 10a. State 10b. County Md NA	1	Oc. City, Town or Lo					100	d. Inside City Lim
one. than "natural", or iteme 23e or 28e-f show the Mudical Examination coulding at	I Director	Md NA 10e. Street and Number 1710 Carswell St	ret	Baich	10f. Zip Code 212	18	1	0g. Citizen of W USa	hat Countr	y?
point. Depointment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show any injury or other traumatic event, the Mudical Examinism must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	, ,	Was Decedent of Hi f Yes, specify Cubar I ☐ Yes 2√2 No	spanic Origin? (Spe	ecify Yes or No- Rican, etc.)		- American c, White, et Bla	c.
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th and Meri 7 le marke traumatic	၉	Crit 19a. Informant's Name/Relationship (Ty			ng Address (Street a				State, Zip C	
ent of Healt at: If Item 2: y or other		Joseph Keaton 20a. Method of Disposition Disposition Disposition Other (Specify)		20b. Place of Dispo	sition (Name of natory or other place	e)	Date	20c. Location - (City or Tow	n, Stete
Depertm Importar any injur		21. Signature of Funeral Service Licens	Wane		Name and Addres		Baltimo 1101	re, Md. E. Nor	212 th Av	
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	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at til 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	of deliver	/ Day Year
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within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	l Certification:	3 Suicide 6 Could not be determined	building, etc.			no date and -la-	281. Location (Si City or Town	n, State)		
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FOE		-								
Ton		30. Name and address of person who c		oth (Itam 23a) (Tuna	-	243894	6	January	1 dd,	2009

		Please	State of Manua				•	•	le.
		1 - For State Registrer	State of Maryla		rtificate of			201	16 11997
		Decedent's Name (First, Middle, Last,			rimouto or	Dodin	2. Date of Dea	eg. No. C	3. Time of Death
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Examin	er	Harmy Loso	ital Cer	2400	Bal-	tima(7	N	IA
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23e o	aiD	514 Oak Grove Ro	oad		21	.090		U.S.A	A •
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a la la la la la la la la la la la la la	edb	15. Decedent's Edu	Year or Dates: WW	16a Dece	dent's Usual Docu	pation		16b. Kind of Busin	ness/Industry
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= 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	tollioval il olli State		matory or other pla ark Cemet				e, Maryland
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or. pa	e Co	25. Was case referred to medical					1 ☐ Yes 2	No 1□	Yes 2□ No
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tor: Alt	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day 19ar)	Injury		Yes 2 □No			
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completely filled in by									
Fune tely fi	Medical	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	sician: To the best of my kiner: On the basis of examin	nowledge, deat nation and/or in	h occurred at the tir vestigation, in my o	me, date and place pinion, death occu	e, and due to the ca arred at the time, da	luse(s) and manne ate and place, and	er as stated. due to the cause(s)
To the Funeral Director: After this certifica completely filled in by the funeral director, it	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	25	9d. Date signed (A	Month, Day, Year)
⊢ ŏ		Yamara Z.	K.L. D.O.		Land Stranger	51791		_	22,2004
XI	1			em 23a) (Type.					- W , W - 1
6		30. Name and address of person who co Tamara L. Kile, D	Baltimo	ive h	10 210	225			
Sta		31. Date tiled (Month, Day, Year) IAN 2 8 2004			ade a				
Registr	ar	JAN & G KUU4	July 180 So	1	36				

		For State Registrar	State of	Marylaı	nd / Depa <i>Cei</i>		nt of He te of C		d Ment		ene g. No. 20 () i, (11998
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Funeral Director		5. Social Security Number 6. S 213 96 9756 1 Usual Residence of Decedent	9x 7. ▼ M 2 ☐ F	Age (In yrs.	. last birthday) Yrs.	If Unde Months	Days	Hours N	Hrs. 8. Da Vin. Fe	te of Birth onth, Day, 0. 23	Year) 1966	Birthplece Country) Maryla	(State or Foreigr and
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ityidilu zihould be filed ad Mental Hygimmerked other metic event, t	10 Be CC	17. Father's Name (First, Middle, Last) Raymond	E. Kowa					18. Mother's			aiden Sumame)	acourt	9
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Pages 1 and nont of Health int: If Itam 2 iry or other		20a. Method of Disposition 1 ☑ Bunal 2 ☐ Cremation 3 ☐ 1 ☐ Other (Specify	Removal from Sta	20b. I	Place of Dispo- cemetery, cren	sition (Na	me of other place,)	Date	2	Oc. Location - Ci	ty or Town, S	State
permil. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service Licen	ramen	rest	22	. Name ar	nd Address	of Facility	orge J	Gor.	ce Fune	ral Ho	me, P.A
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To the Hospitel or Attending Physician: The law requires that the death certificate the Hospitel or Attending Physician: The law requires that the death certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the death of the funeral director, page 2 should be detached for use as the death of t	rnysician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnan 9 Unknown	n 2 ☐ Fete itattime of c	el death 3 🗌	Ectopic pi Other (sp					23d. Date of Month		Year
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nding Physician: The landh. The landh. Tr. Atler this certificate has a funeral director, page 2	anon: 10	1 ☐ Yes 2 ₺ No 27. Manner of Death 1 ₺ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of I		28b. Time of Injury		8c. Injury a Work?	at Indian			ce 6 Other (Specify)	
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4x,		30. Name and address of person who come of the company of the comp	AMBO	of death (Item	n 23a) (Type, F	Srint)	lano	ver :	st, Bo	ultim	ore in	1D 2	1225
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DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	Maryland	-	artment of He tificate of D		lental H	ygiene Reg. No. 2	004	01999
44	Physici /Medic		Decedent's Name (First, Middle, RODERICK		KETT				2. Date of D Month JAN 2.	Death Day	Year	3. Time of Death 9:41 am ^M
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	a within 72 hours after death with the Maryland jiene. r than "natural", or items 23s or 28s-1 show the Madical Examinar must be notified at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD 10e. Street and Number 3222 YOSEMITE 11. Marital Status	12. Was Deced	10c. City, T	BALT	IMORE 10f. Zip Code 2 Was Decedent of His	L215 panic Origin? (Sp	ecify Yes or N	10g. Citizen o	of What Coun	an Indian,
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Div	lospital or All hours after unaral Directly filled in by		4 Homicide determina	Physician: To the b	f tnjury - At home i, etc. (Specify) est of my knowle				City or To	(Street and Nur	=8===	
	To the Hospital or Attendi within 24 hours after death. To the Funaral Director: A completely filled in by the t.	Medical	(Check only 2 Medical Expone) 29b. Signature and title of certifier 30. Name and address of person with	aminer: On the bas and manne	is of examination r stated.	and/or inv	29c. License	nion, death occurr	ed at the time	e, date and place 29d. Date sign	e, and due to ned (Month, L	the cause(s)
	Sta Registr		31. Date filed (Month Day, Year)	GBMC 04 Reg	6701 gistrar's Signature		Charles.	St. Bal	to me	1212	04	

DHMH 17 Rev 1/2001

Registrar